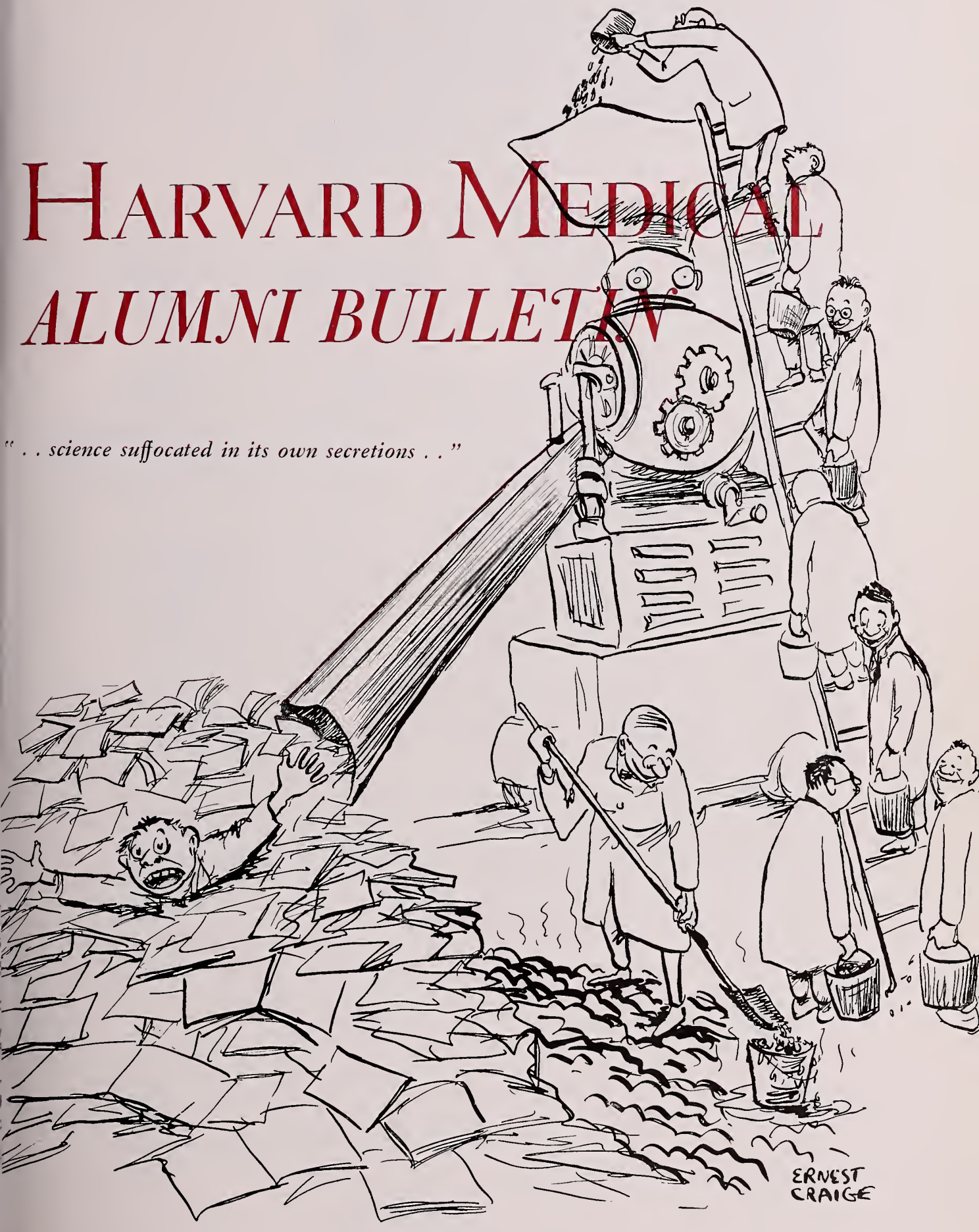
Fall, 1961

HARVARD MEDICAL ALUMNI BULLETIN

" . . science suffocated in its own secretions . . "



New Alvodine®

Brand of piminodine ethanesulfonate *ethanesulfonate*

An analgesic for

1. Ambulatory patients.

Whenever codeine or codeine-aspirin combinations are used, Alvodine taken orally can relieve pain better without dulling mental acuity or enervating the patients.

2. Postoperative patients.

Alvodine injected parenterally is as potent as morphine, but unlike morphine, it permits patients to remain alert postoperatively. It favors early mobilization of patients because it is usually not hypnotic.

3. Cancer patients.

Alvodine produces relief without weakening the cancer patient. Alvodine allows patients to eat normally, to maintain their strength and to continue their day-to-day activities to the extent permitted by their disease.

Alvodine is the first narcotic analgesic with action approaching "pure" analgesia. It relieves pain without producing sedation, drowsiness or drugged sensation.* This unique characteristic makes Alvodine the most desirable agent for pain relief in these three large groups of patients.

Alvodine Tablets, 50 mg., scored.
Alvodine ampuls, 1 cc. containing 20 mg. per cc.
Narcotic blank required.
Write for detailed information on clinical experience, addiction liability, side effects and precautions.

*In more than 90% of patients

Winthrop LABORATORIES
New York 18, N.Y.

new infant formula nearly identical to mother's milk[1] in nutritional breadth and balance

®

Infant formula

Enfamil babies are satisfied babies. Weight gains are good, and regurgitation is minimal. **Normal stool patterns.** Enfamil was compared with 3 other formulas in a well-controlled institutional study.[2] Stool frequency was low, and stool consistency was intermediate between the extremes of firmness and softness.

1. The Composition of Milks, Publication 254, National Academy of Sciences and National Research Council, Revised 1953. 2. Brown, G. W.; Tuholski, J. M.; Sauer, L. W.; Minsk, L. D., and Rosenstern, I.: J. Pediat. *56*:391 (Mar.) 1960.

Mead Johnson Laboratories

Symbol of service in medicine

LETTERS

Bigelovus, Bigelovi, Bigelovi

To the Editor:

I was interested in your cover note in the summer *Bulletin* concerning the flowers named in vain for Jacob Bigelow. Miss Genevieve Cole, the medical librarian of the Massachusetts General Hospital, has informed me, however, that there are still several species (though not genera) named for Bigelow in the current botanical nomenclature.

In Gray's *Manual of Botany,* (1950), page 341, she found *Carex Bigelowii,* a plant of the sedge family, and on page 599, *Salicornia Bigelovii,* a dwarf saltwort. It is stated categorically that both plants were discovered by Jacob Bigelow. Perhaps these two names were derived from the names previously designating erroneous Bigelow genera. On page 850 there is a reference to *Rubis Bigelovianus,* a rose, which is now recognized as a variety of *Rubis Semisetotus.* Miss Cole feels sure that there are additional species named for Bigelow.

This is merely to indicate the wide botanical influence of Jacob Bigelow, the author of *Florula Bostoniensis* and the first Professor of Materia Medica at Harvard Medical School in 1815.

George Jacobsen
Massachusetts General Hospital

The Bulletin in Error

To the Editor:

I would appreciate it if you would correct one error in the summer issue of the *Bulletin.* It is stated on page 60 that I graduated from the Harvard Divinity School in 1959. Although I did attend the Divinity School from 1956 to 1959, I am not a graduate.

Thank you for your courtesy in this matter.

Stuart Q. Flerlage, '55
Massachusetts Mental Health Center

The Bulletin *apologizes for having erroneously graduated Dr. Flerlage from the Harvard Divinity School.*

Mrs. Lee's Murders

To the Editor of the *Bulletin:*

Thank you most warmly for a sensitive article about the nutshell miniatures. I would like to add that admission to the police seminars is by invitation only and is much sought after. We have just completed the 31st of these. The Harvard Associates in Police Science, now having well over six hundred members, is a full-fledged Club with Constitution, By-laws, and officers. I am out here in Chicago now because of our annual meeting.

I hope you can read what I have written. I am nearly blind now. There are six more models in my shop. I shall try to finish them.

Frances Glessner Lee
Hotel Ambassador
Chicago, Illinois

HARVARD MEDICAL ALUMNI BULLETIN

VOL. 36 FALL 1961 NO. 1

The Cover: Dr. Craige's cartoon was not allowed to suffocate in the Bulletin's secretions. In Late Summer Madness on page 12 the author of Diagnosis Deferred winks at things dear to medical progress and to our school.

Along the Perimeter

The new Rehabilitation Center at McLean Hospital.

McLean Steps Forward

Since the admission of its first patient in 1818 — a young man "possessed by demons" which his father had tried to exorcise with a rod — McLean Hospital, the psychiatric division of the Massachusetts General Hospital, has sought through research, continuous expansion of facilities, and treatment, to insure its patients the best medical-psychiatric care available. Well known to all is McLean's impressive "country-home" setting: The hospital's 40 buildings in Belmont are surrounded by 388 acres of woods, well kept lawns, a nine-hole golf course, tennis and croquet courts.

This year, appropriately its 150th Anniversary year, McLean Hospital has taken another big step to prepare patients for their return to active home and community life. October 23 is the ground-breaking date for the ultramodern Rehabilitation Center pictured here, to provide an enlarged day-care program for outpatients and a graduation of activities for the seriously ill hospitalized patients to prepare them for ultimate discharge. The center will house a "Village Green" containing a store, restaurant, laundromat, auditorium, beauty salon and barber shop, bank and post office. Clustered around the Green will be an educational center where adolescent patients will continue their education and an activity therapies area consisting of a library, music, occupation, and recreational therapy areas.

McLean Hospital was the first psychiatric hospital in Massachusetts and among the first in the country. It has served, since its founding in Somerville in 1811, as a lamplighter in the practice of new therapies, and in its whole approach to mental illness. The last 60 years, particularly, have seen a succession of distinguished research scientists contributing from McLean Laboratories to both basic and applied aspects of mental disease.

Now begins another, and challenging, chapter.

Let's Keep the Memorials Up: Oscar C. Tugo Circle

Many who passed the neglected grassy rotunda at the entrance to the Medical School quadrangle this summer had occasion to laugh and cry in pity for the anonymous and apparently forgotten Oscar C. Tugo in whose honor the Circle is named. I, for one, several times had the urge to plant a few poppies among the beer cans and tall grass of the Circle, if only to lend a semblance of Flanders Field and remind passers-by that Oscar C. Tugo was not a city functionary, but a hero of World War I.

It is a pity more students are not aware of who young Tugo was, and why this little circle is named for him. This school was one of the first to send a hospital unit to France for medical support in the First World War. Among the enlisted corpsmen who joined the unit at its organization was a shipping co-clerk, Oscar C. Tugo. His company commander, Dr. George P. Denny,* often told me the story of Tugo's devotion to his duties.

*A memorial to Dr. Denny, who died on July 15, is carried on pages 50-51 of this issue.

It was on a bright September night, forty-four years ago, that a German plane dropped a string of five small bombs across the recently activated Harvard tent hospital. Tugo was on duty and rushed to his ward marquee with the nurse behind him. At the opening he received the full force of the fourth bomb. Fortunately, his proximity to the explosion shielded the nurse and the patients. He and two others were killed instantly and were the first American soldiers to lose their lives in action in the War. The incident is recorded on the marble pillar at the entrance to the Medical School grounds, but the lettering does not catch one's eye. The small black sign with gold lettering emerging from this little circle like a neglected grave is the only visible reminder. Along with the unfortunate Louis Pasteur Avenue, the circle is under the aegis of the Public Works Department of the City of Boston. And, indeed, it appeared the City had run through the circle at least once during the summer. Not enough effort was expended to harvest the crop; but a few of the grasses were bent double.

It is appropriate that this plot, close to Vanderbilt Hall and the Medical School, should have been named for Oscar C. Tugo, not only because of his sacrifice, but because it may remind us all of our tenuous clasp on life. Tugo hoped to enter HMS and might have been a graduate of this school, had he lived.

Memorials can contribute more than the rescue of a name from oblivion; they can serve as an inspirational symbol to others, making persons and nations stronger, if their meaning is remembered. During the Blitz of World War II, the dome of St. Paul's Cathedral in London, showing her people that she had survived the night's bombing, gave the strength to fight on another night.

Perhaps your daily passage across this circle may give you, if not exactly inspiration, a little humility to work harder. As you wade through the circle on your way to and from classes, think of this as a memorial both to what was, and to what might be.

THOMAS A. WARTHIN '34

P.S. As the fall Bulletin *went to bed, the grass had been cut on Oscar C. Tugo Circle, and the City Council announced,* mirabile dictu, *the imminent resurfacing of Ave. Louis Pasteur.*

Project Archive

In a fourth-floor room of Building A, sharing space with Supplies, are the first lodgings of the Medical School Archives, School of Public Health Archives and Dental School Archives, all entrusted to the care of Robert W. Lovett, Curator of Archives at the Medical School, and his assistant, Miss Ruth Linderholm. Although he is also the curator of Harvard Business School Archives, Mr. Lovett spends two days a week at the Medical School.

Archives has the modest goal of collecting everything ancient and current about the Medical School and its Faculty and makes the plea that it be kept in mind when you are cleaning house. They love information about buildings and property; pictures, especially portraits of faculty members; significant news clippings; and any information on medical clubs such as Aesculapian and Boylston. They thrive on old medical records and letters; and lecture notes, both faculty and student. Archives has found student notes to be especially helpful in discovering what was taught in early H.M.S. days — but unfortunately not so helpful now, due to the lapse in compulsive penmanship! (Mimeographed curriculum notes are far more useful for current records.)

Oscar C. Tugo Circle (Vanderbilt Hall in background) David Lawlor

Avec "Les Mauvais Coups," c'est certainement l'un des meilleurs films français que vous pourrez voir prochainement à Paris. Aux côtés de Reginald D. Kernan, Simone Signoret dans le rôle le plus caractéristique de sa carrière. Reginald Kernan '44, the School's newest light in the cinema, sent this teaser, which he feels inappropriate for hanging in the Faculty Room, "but only because of its size."

With regard to new material, Mr. Lovett mentioned only one archival problem that frequently arises, weeding! This job often seems better left to some future archivist who, 50 years from now, may have gained perspective. Apparently, now, the only thing that one can definitely discard immediately out of a carton of 30 years of office records and letters is the blank stationery — and who knows what value even that might have in 50 years!

Archival materials had been preserved informally by certain individuals for some time at the Medical School. Ex-Librarian Miss Anna Holt made a collection in her office of historical material on the Medical School and the early faculty members, which is now a major part of the archive collection. But it was not until 1947 that a serious attempt was made to establish a Medical School archive. At that time Mr. Lovett, then termed "roving archivist," was commissioned to come over one day a month from Harvard University Archives to visit the medical library, make a survey of records, and begin an archive. To suit his lofty aims, he was given a lofty perch on the fifth floor of Building A, above the heat in winter and breezes in summer, where, after ascending the five flights of stairs, he had to mount a ladder to reach his materials, then stored on top of some cabinets. Gradually, he found he came less often, and, finally, he stopped coming. Archives were "put aside" for two years, from 1955 to 1957.

In the mushroom growth of the post-Esterquest period, the fourth floor supply room was made available to Archives and Mr. Lovett resumed his visits and began, inch by inch, to replace Supplies with Archives. Although he still shares space with Supplies and admits that the arrangement is not ideal, Mr. Lovett hastens to add, "It's far better than before."

The silver lining is that now Archives can view its present spot as only temporary before it takes up new quarters in the Countway Library of Medicine. Such glamorous innovations as air conditioning will then be enjoyed, and there are already plans for an attractive reading room and exhibits.

A man with little time or space, but an unbounded enthusiasm for his many projects, Mr. Lovett hopes, among other things, to go through the Deans' records from 1906 to 1950, almost a roomful in the basement of Building A; and to examine the stack of matriculation books to make a record of not only the graduates but every person who ever attended Harvard Medical School. Meanwhile, Archives continues to welcome all inquiries and, of course, all new, or old, archival material.

The Warren Museum in Flux

With the retirement of Paul I. Yakovlev as Curator of the Medical School's venerable Warren Museum, Don W. Fawcett and George E. Erikson, both anatomically inclined,* succeed to the posts of Curator and Associate Curator, respectively.

The Warren Museum with its immense collection has long seemed to slumber under the skylights, bounded by the iron balustrades and stairs which separate the rarer regions of Building A. The medical students who pored over neurological slides were a sporadic phenomenon; the research workers disturbed the atmosphere very little. Throngs of children and the curious, attracted by the grislier exhibits, came and left. There were also the Faculty wives who could think of no more pleasurable way to preface their teas than by taking a tour of the bottles and bones; and many came, searching for the famous "crowbar skull," and the miniature guillotine, whose creator proved its effectiveness upon his own neck.

None of the curious opened the door to that most secret of closets enclosing the skeleton of the second of

*Dr. Fawcett is Hersey Professor of Anatomy and Head of the Department of Anatomy; Dr. Erikson, Assistant Professor of Anatomy.

the great Warrens, Dr. John Collins; for the legal stipulation provided that only the Curator, accompanied by one member of the Warren family, might look upon the bones of the Museum's founder.

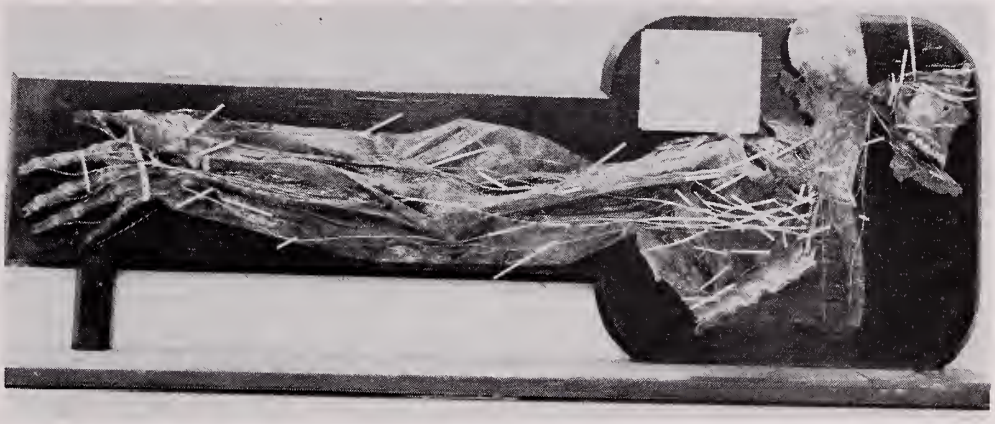
In 1955, the Museum was reorganized to serve additionally as a research and postgraduate teaching unit. As a neurologist, Dr. Yakovlev has, during his six years as curator of the Museum, stressed aspects of the Museum's function relevant to the Basic Neurological Sciences and Neuropathology. He has assembled a collection unique in this country of over 100,000 serial sections of human and animal cerebra.

Anno 1961 found new changes: Archives had moved up onto the fourth floor; both Mr. Esterquest, the Librarian, and former Dean C. Sidney Burwell had possessed themselves of pastel offices on the same floor — offices less redolent of preserving fluid than some in the Museum.

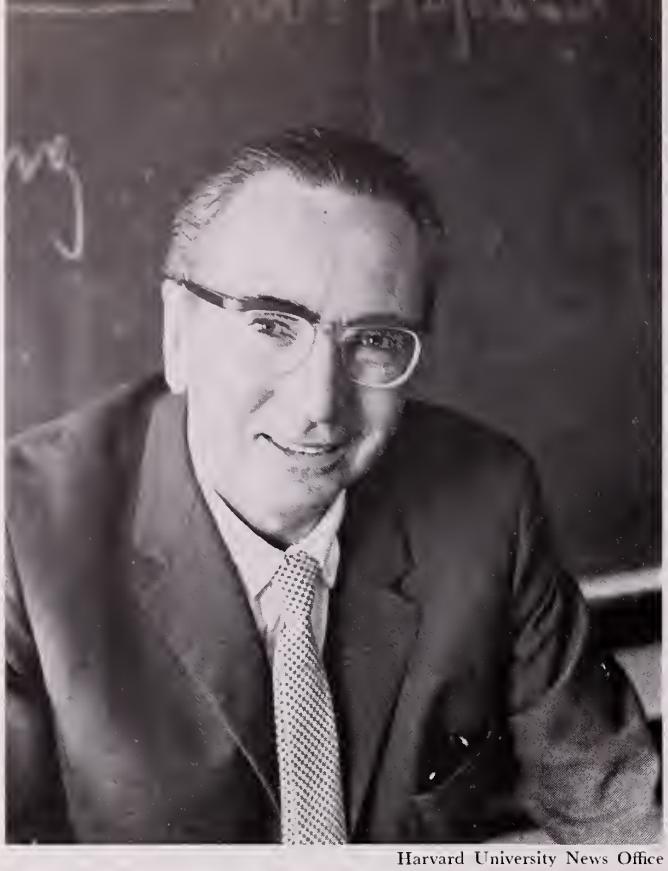
With a sudden increase in tempo, the Museum was roused early this year from its quiet, as the successive renovation of the Quadrangle buildings raised a pressing need for more classroom and laboratory space. A portion of the Collection saw itself packed into boxes marked "Cheerios" and "Kleenex," and moved to the "Combined Hospital Laundry" next door to Fenway Park. Oliver Wendell Holmes's bust snubbed its nose for a time against the high piled packing crates, while the statue of Hermes moved downstairs in pristine glory to the Library landing.

On the third floor, six new student classrooms were installed last summer, and thirty to forty per cent of the floor areas on the fourth and fifth floors have been con-

David Lawlor



Right: John C. Warren's dissection of the brachial and cervical plexus and of cranial nerves. This is one of the earliest items in the original Warren collection which John C. brought partly from London and partly prepared himself in Boston. Below: (Lawrence Collection) Growth of human skull from third fetal month to adulthood and (Wyman Collection) human skeleton from fifth week to term.



Harvard University News Office

Dr. Viktor E. Frankl

verted to laboratory and research space. By shifting display cases to accommodate the space behind them, classroom, laboratory and research space was created with a minimum disturbance to the Collection. Dr. Erikson plans to display some of his beautiful primate collection in the cases, relocated in the main hall of the third floor.

Dr. Yakovlev's collection of brains in serial sections has been moved from the third floor and installed on the galleries of the fifth floor, where it will best serve the needs of research in the anatomy and pathology of the nervous system. The research laboratories of the Department of Neurology and Neuropathology are now relocated on this floor, where Dr. Yakovlev, now *emeritus,* will continue his studies of perinatal pathology and normal development of the human brain under the auspices of N.I.H. The space thus made available on the third floor will serve the needs of teaching students in the Department of Anatomy under Dr. Fawcett. The central space of this floor will be used for the display of the most valuable and interesting Collections of the Museum.

On the fourth floor are the research laboratories for cellular neuropathology under Dr. Raymond Adams and Dr. Richard Sidman. Dr. Sidman cautions visitors not to confuse the specimens with the research workers.

The Doctor and the Soul: Dr. Viktor Frankl

The well-known author of *The Doctor and the Soul* and *From Death Camp to Existentialism* brought with him to Harvard's Summer School the rare combination of a fine mind, human sensitivity, and subtle but gentle sense of humor when he came to teach this past summer. The eminent neurologist and psychiatrist taught two courses in social relations, "The Abnormal Personality," and "Existence and Values: Foundations of Logotherapy."

Dr. Frankl spent three years as a Nazi prisoner in four different concentration camps, in one of which his entire family (including his wife and children), with the exception of one sister, perished. It was during these years, working with other prisoners and living from day to day under hopeless conditions, that he crystallized his version of modern existential analysis.

On August 7 he joined four psychologists and psychiatrists in a Brattle Street Forum discussion on "The Public, the Patient, and the Psychiatrist," televised from the new Loeb Drama Center. At the Forum, Dr. Frankl dealt with a term he himself has coined: *Logotherapy.* The basis of Logotherapy he terms man's "will-to-meaning," his "deep-seated striving and struggling for an ultimate meaning to his existence." Several of Dr. Frankl's co-panelists inclined rather strongly to the belief that troubled contemporary man has no more "ultimate" concern than his worry about where the next meal will come from, how to pay for medical care, school clothes, and the rest. Dr. Frankl answered with Nietzsche's words, "He who has a *why* to live for can bear almost any *how.*"

The widening scope of psychiatry, Dr. Frankl felt, now brings the man who would have formerly consulted his priest about his worldly and spiritual problems to his psychiatrist. He warned against the danger of mistaking symptoms of universal "humanness" for neurotic ones. The so-called "little" worries that afflict man are actually symptomatic of his longing for an ultimate meaning.

In commenting on the increasing rush of the U.S. public to the psychiatrist and psychoanalyst, Frankl noted the more relaxed attitude of Russians toward new psychotherapies. Russians, he felt, are more committed to their life tasks, (voluntarily or not). Here in the U.S., where booming urbanization and industrialization give ever-increasing leisure, there is a growing need to commit oneself. When one finds no commitment, each according to the uniqueness of his own personality and of each situation, he enters into what Frankl calls "existential frustration." The person then becomes threatened by the existential vacuum within himself. "As a clinician," said Dr. Frankl, "I must add that it is precisely in this existential vacuum that many neuroses become rampant."

In the book *From Death Camp to Existentialism,* written about his experiences as a Nazi prisoner, Frankl recalls two men who wanted to commit suicide because they "had nothing more to expect from life." Frankl noted the necessity of "getting them to realize that life was still expecting something from them. . . ."

On August 15 Dr. Frankl returned to his own tasks — as Professor of Neurology and Psychiatry on the Medical Faculty of the University of Vienna, and Chief of the Neurological Department of the Policlinic in Vienna, where he lives with his second wife and child.

INSIDE H.M.S.

MEDICAL INTELLIGENCE

There is not much in the medical literature regarding private dormitory cooking. The concept deserves exhaustive investigation, at least from psychiatric and metabolic standpoints, because trying to sustain the body machinery from a hotplate encroaches upon the very extremes of sanity.

After the second year, students are freed from dormitory dining-hall contracts, and it is about this time that they are mature enough to appreciate the copious advantages of attempting to prepare a palatable repast in a dormitory room obviously not meant for such a function. Among the more obvious advantages are: 1), the *decisively* reduced cost of eating; 2), an ever-desirable menu from which to choose *any number* of succulent dishes, and 3), the absence of dietary regimentation.

Several independent laboratories have shown the sheer fallaciousness of these prospects. In our laboratories, for example, three reasonably normal medical students were selected with heavy bias, to prepare three meals a day for seven days. They found that they had to work four hours a day to prepare three meals and were forced to miss classes and clinical assignments in order to assure themselves even a modest caloric intake. The incidence of gastrointestinal upset in this sample increased from zero to 100%, and 66⅔% of the group was found to be debilitated by metabolic acidosis.

One hundred per cent of the group was unable to agree at any one time on a suitable menu, and 33⅓% of the group insisted upon exotic salads, fruits, nectars and garlic at each meal. One hundred per cent of the group became irritable around meal-time, and even more irritable after eating. Observers utilizing the one-way glass felt that had not the GI symptomatology been so severe, aggressive tendencies might have been quite openly expressed.

Of interest was the fact that no more than 66⅔% of the sample was ever available at the conclusion of a meal to clean up. While some of this truancy was attributed to nothing less than malingering and hysterical absenteeism, in several instances 33⅓% of the group was on his way to the health center hard by the dormitory when the meal had been brought to its savage resolution.

It is unfortunate that this report holds so closely to actuality. Trying to cook under the handicaps imposed by the dormitory and to attend medical school almost concurrently is a burden which few can take without significant psychological sacrifice. Seneca is supposed to have said that there has never been a genius without a spice of madness. We can take some comfort from this. It was noted that our group was heavy-handed with the seasoning.

DRIVING TO DISTRACTION

Probably no subject sequesters as much time in student-faculty committee meetings as Vanderbilt Hall and its allied humanitarian operations. One operation — the parking lot — is now seen to obey a parody of Parkinson's second law of economics (the law states that "expenditure rises to meet income"). For many years the student-faculty committee deliberated the embarrassed parking quarters behind the dormitory, and, when at last an expansionist movement toward the heart of the Fens was announced, the committee believed that for a few years the parking situation would occupy less of its time.

Interestingly, as the lot expanded, the number of cars to be parked in it increased exponentially. Presently the parking lot is filled before 8 a.m., and would-be parkers are thereafter rebuffed by burly, gruff-talking *agents de police* (Harvard-style). In the final analysis, there is only one rational solution for upperclass students to submit: no automobiles for first- and second-year students. Understandably the second-year men have developed an alternate plan whereby first-year students would operate no cars. This leaves first-year students without much of a plan.

A good deal has been written of the automobile as a psychosocial phenomenon. In the present situation what has been demonstrated is that an enlarged parking area begets only the need for an enlarged parking area in what must be regarded as a vicious psych-cle.

Pepper Davis, '63

The Thomas H. Lanman Memorial

Gifts for Dr. Lanman's memorial continue to be received at the Alumni Office. Gifts heretofore unacknowledged have been received from:

Dr. Hart Achenbach '50
Mr. Copley Amory
Dr. George P. Berry, Dean
Dr. David Jacobs '28
Dr. Herbert W. Jones '37
Dr. Harold R. Merwarth '21
Mrs. W. Jason Mixter

James Howard Means, With Gusto

On June 7th of this year, the Massachusetts General Hospital opened the doors of the new James Howard Means Metabolic Research Laboratories in the basement of the old Bulfinch Building. This is an appropriate location, declared Dr. C. Sidney Burwell at the dedication, since "it is in the cellars of hospitals where research activities germinate (like mushrooms)."

Dr. Burwell paid tribute to Dr. Means for his distinguished careers in four areas: patient care, research, teaching and administration. "However," Dr. Burwell went on to say, "no one who knows of him would think of limiting his careers to these." Dr. Means is also the author of many volumes: *Ward IV; Doctors, People and Government;* and, just recently, a History of the Association of American Physicians. "It is a pleasure to think of someone actually enjoying writing," said Dr. Burwell. "I think I can visualize Dr. Means sitting at his desk plunging happily into the writing of this history." Dr. Burwell characterized Dr. Means's unique quality and salient characteristic as "gusto," and added: "Dr. Means has retired from the Harvard Medical School, from the Massachusetts General Hospital, and from the Massachusetts Institute of Technology, but I am not able to describe him as a naturally retiring man."

New Appointments

A. Clifford Barger, '43A, has been appointed Professor of Physiology at Harvard. Noted for his research on coronary artery disease, Dr. Barger was first to produce congestive heart failure in experimental animals similar to that observed in man. More recently, he has succeeded in placing permanent catheters in the coronary arteries of experimental animals enabling him to study the possible relationship between nervous tension and the development of coronary artery disease. Earlier studies, dating from 1950, were concerned with abnormal kidney function in relationship to circulatory insufficiency.

Currently active in the teaching program at the Medical School, Dr. Barger also serves as chairman of the Curriculum Committee for the first year of medical study.

* * *

Gustave J. Dammin, a pathologist whose research in the area of tissue and organ transplantation and in cardiovascular and renal disease has received international acclaim, has been appointed the first Elsie T. Friedman Professor of Pathology at Harvard. Recently established at H.M.S., the Friedman Professorship is a gift to the University from the trustees of the Elsie T. Friedman Charitable Foundation of Boston.

As Pathologist-in-Chief at the Peter Bent Brigham Hospital since 1953, Dr. Dammin was responsible, with his colleagues, for the development of the series of tests used in the first successful transplantation of a kidney in unidentical twins. Dr. Dammin's tests involved a series of skin grafts between donor and recipient to determine whether they were, indeed, identical twins. With one exception all successful kidney transplantations to date by the medical-surgical group at the P.B.B.H. have involved identical twins.

Dr. Dammin will also serve as director of a new Cardiovascular-Renal and Transplantation Center soon to be established in the Tackaberry Building at the Brigham with the help of a half-million-dollar grant from the National Institutes of Health.

* * *

Dr. Herman M. Kalckar, who applies the principles of biochemical genetics to the understanding and treatment of disease, has been named Professor of Biological Chemistry at Harvard.

With fundamental research his primary concern, Dr. Kalckar will also work toward the orientation of biochemistry to diseases in general. His laboratories will be at the Massachusetts General Hospital, where he will have an extensive staff of young research biochemists.

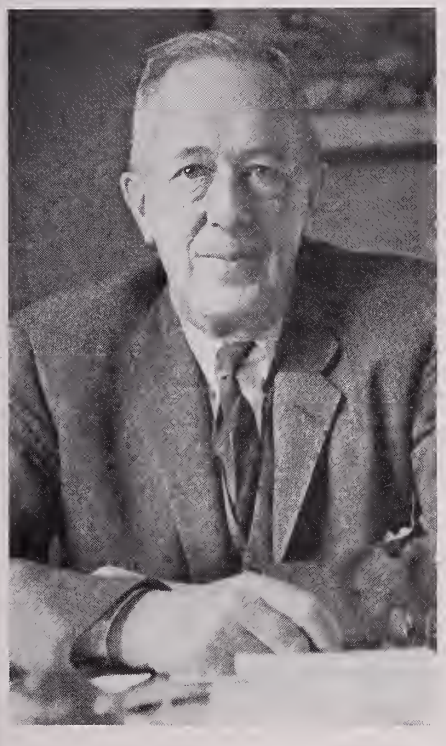
His basic studies on the metabolic enzymes led Dr. Kalckar in the middle 1950's to initiate chemical studies of human hereditary diseases, especially congenital galactosemia. With Kurt J. Isselbacher, '50, Assistant Professor of Medicine at Harvard and the M.G.H., and others, Dr. Kalckar demonstrated that this disease was the result of a congenital deficiency of an enzyme handling a nucleotide-hexose essential to the body's metabolism of galacto to glucose.

* * *

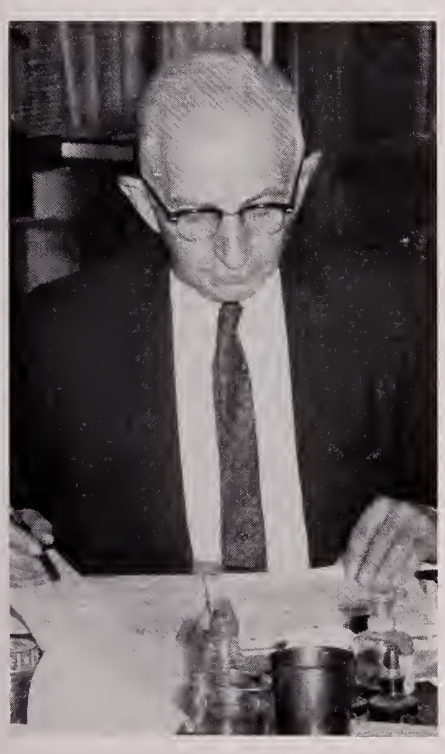
Donald D. Matson, '39, has been named Clinical Professor of Surgery at Harvard. Specializing in research on the congenital defects of the nervous system and on their surgical treatment, Dr. Matson has been Associate Clinical Professor of Surgery at Harvard since 1955. He is also Neurosurgeon at The Children's Hospital and Neurological Surgeon at the Peter Bent Brigham Hospital.

Retirements

Three members of the Faculty of Medicine have retired to become Clinical Professors, *Emeriti,* CHARLES C. LUND '20 as Clinical Professor of Surgery, DR. PHILIP E. MELTZER as Clinical Professor of Otology, and DR. PAUL I. YAKOVLEV as Clinical Professor of Neuropathology.



Dr. Lund



Dr. Yakovlev

In addition to his important studies on protein metabolism in surgical patients, Dr. Charles C. Lund has contributed to the treatment of burns and cancer diagnosis. He was, until his retirement in 1960, Acting Head and Surgeon-in-Chief of Harvard's Fifth Surgical Service and the Sears Surgical Laboratory at the Boston City Hospital. Dr. Lund is a past president of the Massachusetts Medical Society and the American Cancer Society. In 1958 he was President of the Harvard Medical Alumni Association.

A native of Boston, Dr. Lund received the A.B. degree in 1916 and the M.D. degree in 1920 from Harvard.

Dr. Philip E. Meltzer, a leader in the development and application of surgical procedures for the relief of deafness, is noted for the development of a technique for the removal of adenoid tissue from the nasopharynx in children.

Born in Boston in 1895, Dr. Meltzer received the D.M.D. degree in 1915 and the M.D. degree in 1918 from Tufts University. From 1937 to 1957 he was Professor of Otolaryngology at Tufts University and was cited by the President of Tufts in 1957 for his contributions in this field. He is a former president of the American Otological Society and the New England Otolaryngological Society, and was first vice-president of the American Academy of Ophthalmology and Otolaryngology.

Dr. Meltzer will also retire as Acting Head of the Department of Otology and Laryngology at Harvard and as Chief of Otolaryngology at the Massachusetts Eye and Ear Infirmary.

Dr. Paul I. Yakovlev is internationally recognized for his studies of brain malformations. Born in Touretz, Russia, in 1894, he received the Bachelor of Medicine degree in 1919 from the Military Medical Academy in Leningrad and the M.D. degree in 1925 from the University of Paris. He came to the Harvard Medical School in 1925 and, with the exception of a four-year period, has been associated with the School since that time.

Dr. Yakovlev is a former president of the American Association of Neuropathology and the Boston Society of Psychiatry and Neurology. He was (1950-58) vice president of the American Board of Psychiatry and Neurology and (1958-59) was first vice president of the American Neurological Association; currently he is first vice president of the Society of Biological Psychiatry. In 1955, Dr. Yakovlev received the Max Weinstein Award for outstanding scientific achievement in the field of cerebral palsy.

Dr. Yakovlev will also retire as Curator of the Warren Anatomical Museum at the Harvard Medical School. However, he and his staff will continue his neurological studies in the refurbished laboratories of the Warren Museum, under the auspices of the National Institutes of Health.

". . . one room in the house he must not enter."

DIAGNOSIS DEFERRED

LATE SUMMER MADNESS

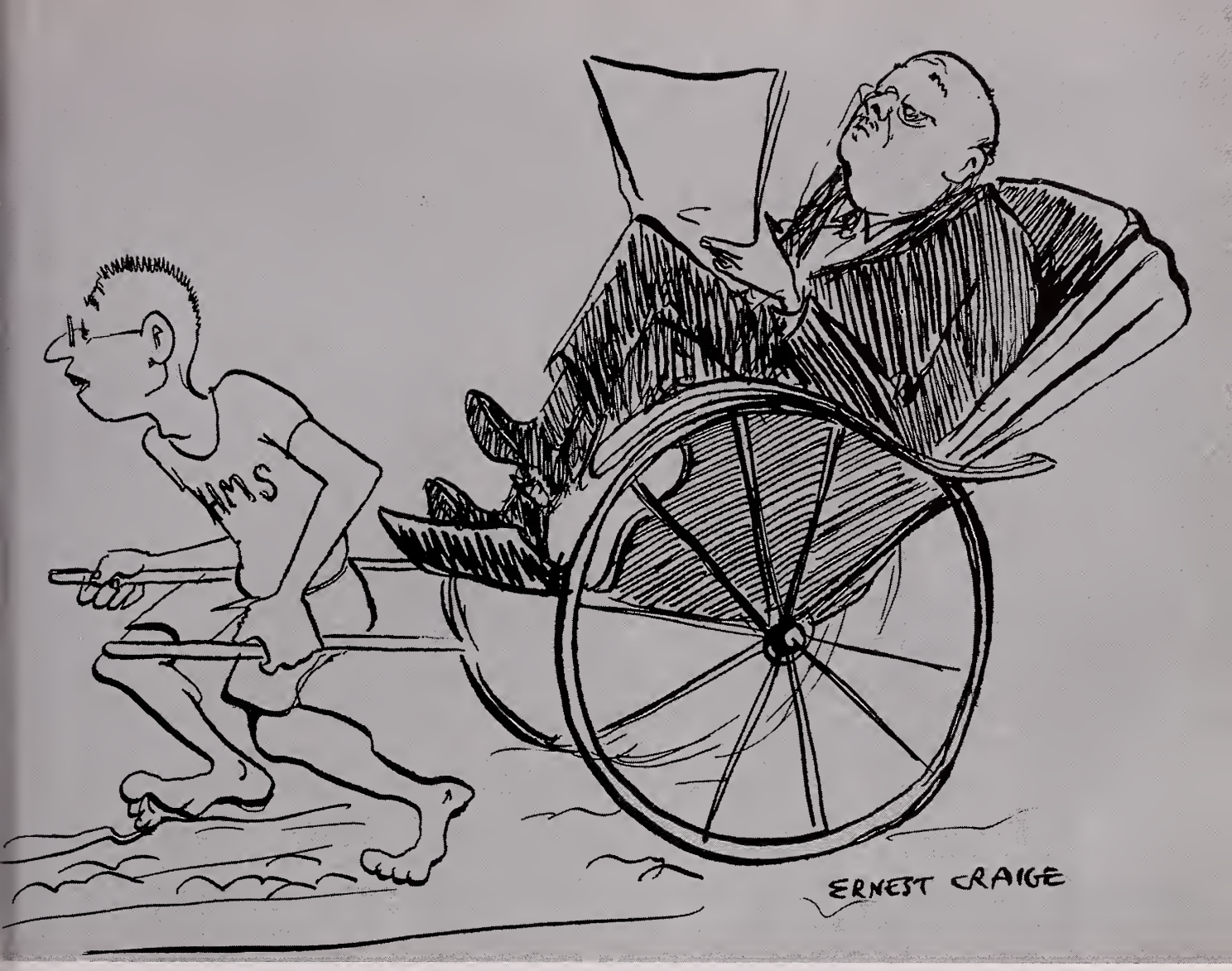
PROFESSOR Rutstein, in his exhortation to the Boylston Society on the occasion of its hundred and fiftieth anniversary, called attention to the fact, generally recognized, of the late rapid increase in medical knowledge and the increase, perhaps more important still, in its literature.

Currently, or at the last count, the Boston Medical Library contained approximately 400,000 items, including volumes and pamphlets; in addition some 100,000 uncatalogued volumes, 300,000 uncatalogued journal issues and a quarter million uncatalogued "European doctoral dissertations," of all things, occupied space upon its shelves or on the basement floor. It has been estimated, moreover, according to the professor of preventive medicine, that there are well over 23,000 medical and paramedical journals in publication, of which at least 13,000 are purely medical. In this relation "journal" is undefined; the number may be considerably exaggerated if hospital and district medical society bulletins and newsletters and trade publications are included.

As Sir Robert Hutchison wrote in 1939, "Must we sit still and see science suffocated in its own secretions, or can we do anything to mitigate the evil?" As an illustration of the evil he related the experience of a young British physician who went down to the country to act as locum tenens for a practitioner going on a holiday. Like Bluebeard, the local doctor told him of one room in the house he must not enter. Naturally, as soon as the older man had disappeared down the lane he burst into the forbidden chamber "only to find it stuffed from floor to ceiling with unopened medical journals. Such was the elderly practitioner's grisly secret."

Dr. Rutstein, with his organizational genius and his determination that nothing of value should be lost to the world, expressed concern over the difficulties of storing and retrieving the mass of medical information that is inundating this division of learning. Serious consideration, he insists, must be given to the electronic indexing, salting away and retrieving of knowledge, but of at least equal importance would be a means of systematic communication among editors of medical journals and a stiffening of editorial backbones so that worthy material would not be too often duplicated and the unworthy would not be published at all.

In regard to the storage and index-



". . . rickshas drawn by needy barefoot students . . ."

ing of the worthy, the National Library of Medicine may be relied on for a steady major effort, even if a slowly losing one, and the Countway-Boston Medical Library axis, when it materializes in whatever building material is then current, can be expected to further the more desirable objectives of librarianship.

Then, indeed, may major changes be expected in the *Civitas Hippocratica Harvardiana,* bounded, rumor has it, by Longwood and Huntington avenues and Francis and Binney streets. Shattuck Street, its disrupted asphalt used for fill in some remote area, will become a grassy greensward for the new Harvard Medical Yard to an even greater degree than the original Harvard Yard in Cambridge will be restricted to foot travel — a novelty to many members of a generally unperipatetic profession. Possibly a few pushcarts will be permitted to carry weightier goods between the more distant points of the compound, but whether or not rickshas drawn by needy barefoot students will be encouraged to glide over the sylvan walks has not yet been considered by the Dean's office; or if so no statement has been issued.

It seems to be practically certain, however, that the Marble Quadrangle will not be turned into a parking lot, as had been suggested by a number of relatively important personages and discussed by J. Englebert Dunphy at a recent Alumni Day gathering. Like he (or she), probably in search of status, who dreamt of dwelling in marble halls surrounded by vessels of surf, those in authority have decided against any innovations, however practical, that might affect the classic simplicity of what may eventually be called the *Old Campus.* And anyone who disagrees can pick up his marbles, like Lord Elgin, and go home.

As a matter of fact, the proposed parking lot somewhere to the south of Huntington Avenue may yet materialize, although if too long delayed it might meet with serious competition from a solution of parking troubles in general, on which the writer has been working for some time and which holds considerable promise. This consists of a two-dimensional automobile which takes up no space whatsoever. Being two-dimensional, it would require no bolts and, possibly, no nuts. Its plans have been perfected up to the point where the only remaining technical problem is the elimination of the third dimension.

Editorial

GROUP PRACTICE AND THE TEACHING HOSPITAL

The fundamental concepts of "group practice" have, until recently, been considered incompatible with the academic amalgam of medicine, which today must include the care of the patient, teaching and research. Academicians have considered group practice to be a way of life for community clinicians but not for larger institutions more fundamentally oriented toward training and investigating. But they forget that the clinic idea — the association of doctors for the *care* and *study* of patients — had one of its earliest trials at Johns Hopkins Hospital.

World War II eventually provided a stimulus to the formation and growth of group practice by pointing up the advantages of specialization and the amalgamation of specialists in the armed forces.

Group practice was born of two needs: that of the patient and that of the doctor. The overwhelming volume of scientific information makes it presently impossible for any one physician to be an authority on more than one or two areas of disease. Specialization into distinct fields and the grouping of such specialists under one roof allows this new scientific knowledge to be efficiently implemented. A patient entering a clinic can now be assured that he will receive properly qualified care through consultation within the clinic rather than through the more complicated and more expensive system of referral among doctors at a distance; and group practice lends itself to prepayment medical plans as easily if not more easily than any other present medical care arrangement.

The physician, in return for loss of some individual independence, also obtains benefits from group practice. Today's doctor knows the advantage of specialization and at the same time the impossibility of being a specialist in a number of fields. The presence of easy referral within a group clinic simplifies his problem and allows several heads to be brought to bear upon each clinical problem. There are many obvious economic advantages to the doctor as well, in the areas of tax benefit, pension and so forth. Also, there is better coverage for the doctor himself, should he wish to be away or wish to attend scientific meetings for self-improvement.

Today in America, there are over one thousand medical groups. Since 1946, the number of medical groups has tripled and there is every reason to believe that this geo-

metric progression will proceed onward. An excellent example of the growth and development of a clinic in a rural area may be found in the Rip Van Winkle Clinic which Dr. Caldwell Esselstyn describes in the present *Harvard Medical Alumni Bulletin*.

Dr. Edwin P. Jordan, Director of the American Association of Medical Clinics, points out that the multiple-specialty clinic is a "phenomenon indigenous to North America." Including any group of five or more doctors in different specialties who have grouped together, these clinics are flourishing in Canada and the United States, especially in the non-seaboard areas; and happily these are areas heretofore relatively devoid of medical care.

Our teaching hospitals and academic institutions represent in many respects the ultimate in specialization and cross-consultation among specialists. And yet, we can learn much from this gathering group-practice experience and already are so doing. Certainly the concepts of group practice need be no less applicable to large teaching hospitals than to group clinics. Indeed, many institutions are now organizing themselves along these lines.

Our institutional hospitals need to realize the importance of supplying to the patient more up-to-date, on-the-spot complete coverage for his problems. For example, the Peter Bent Brigham Hospital has recently set up such coverage for patients coming to their Out-Patient Department. Patients entering for evaluation will be seen during one visit by consultants in each of the fields to which their diseases apply. The plan avoids the multiple-return-visit concept and allows a more rapid solution for the patient's problem. Laboratory data, x-rays and clinical findings will be correlated by one physician as other consulting specialists add their advice to the problem at hand. The result can only mean an improvement in patient care in an outpatient-ambulatory manner that promises to become the mode of medicine for the future.

Dr. Francis Peabody gave his description for the model diagnostic clinic and it may well serve as the ideal for all medical-school groups. "At its best, the patient finds himself in the hands of a wise, broadly trained physician who handles his case personally and refers as the case demands to associates who are skilled in special fields. One man has personal supervision over the case and devotes enough time to it to grasp all its ramifications so that he can estimate the relative importance of the findings of the specialist."

J. R. B.

RIP VAN WINKLE CLINIC

A NAME is a very important part of an institution. It must fulfill certain criteria. In the first place, it must be impersonal and it must also be ageless. It must be easy to remember and, if possible, it should suggest geographic location. These were the principles set forth by comedian and philosopher, Ed Wynn, in naming this Clinic after one of the characters created by Washington Irving, who spent two years in this county which looks across the upper Hudson Valley toward the Catskill Mountains.

Fifteen years ago, two general practitioners, a dentist, a surgeon, and a part-time X-ray man started the Rip Van Winkle Clinic in rural Columbia County, New York. Today, thirty-three full-time and four part-time staff members are demonstrating the concepts on which the organization was founded:

Through group practice, it is felt, well-trained medical personnel can be attracted to rural areas; one way to distribute specialty care and provide comprehensive service is through the establishment of a central office with integrated community clinic offices strategically located throughout the area served; the indoctrination of a community in the interest of medical care can best be accomplished by integrating the clinic as another one of the community agencies; and finally, the payment of total health care on a flat fee basis is practical and acceptable to both patient and doctor in a rural area.

To discuss these concepts in order:

RECRUITING FOR RURAL AREAS.

During the past thirty years the number of physicians in rural areas has been declining throughout the United States. Similarly, the doctor-patient ratio in rural upstate New York has been steadily declining. Today, the New York State Medical Society has fifty-eight requests from communities of 10,000 people or less in upstate New York which are in urgent need of a doctor. The Governor has an unprecedented number of similar requests on his desk from communities in need of doctors. The necessity of bringing about a better distribution of medical personnel is urgent at the present time, but will become even more critical when the doctor-patient ratio for the whole country decreases, as it will in the years just ahead. The Clinic is attempting to meet this problem in three principle ways.

First, the Clinic has accepted the fact that the day of specialization is here. Every effort has been made to see that physicians do not have to accept responsibility in areas in which they are not comfortable. This has not been entirely possible in every instance because of staff limitations, but it is a self-limiting problem.

Secondly, by the time physicians have become Board eligible (a minimum Clinic requirement), unless they have come from families of independent means, they have pretty much reached the end of their financial resources — in fact, they are frequently in debt. Most of these physicians are married and have children; as a matter of fact, one of the reasons for wanting to come to the country is that they prefer to raise their children on sod rather than asphalt. In order to provide a certain measure of security, a salary is made available at the start to everyone.

Finally, and probably most important of all, is the necessity to establish and maintain an academic atmosphere. It is fully realized that the further away an

---

Dr. Esselstyn is founder and serves as Surgeon as well as Medical Director of the Rip Van Winkle Clinic. A graduate of Yale and Columbia University College of Physicians and Surgeons, he maintains a flying connection with H.M.S. through his yearly talk to the third-year students in Dr. David Rutstein's course in Preventive Medicine. He is President of the Group Practice Association of America, Chairman of the Medical Care Section of the American Public Health Association and is a faculty member at Albany Medical College and Seton Hall School of Medicine and Dentistry.

organization happens to be from an ivory tower, the greater effort must be put forth to maintain some kind of an academic environment. Although this adds appreciably to the cost of medical care, it is essential. At the R.V.W.C. an attempt is made to accomplish this in several ways. First of all, there is dinner for everyone on the staff every Thursday night. This may not sound like an extremely exciting academic exercise, but a great deal of medicine is passed with the bread and butter, and an opportunity for an unlimited number of curbstone consultations is provided. It furthermore provides a forum for that intercommunication which is such an essential ingredient of group practice. Following dinner, there is a formal meeting at which deaths, autopsies, mistaken diagnoses, and difficult or interesting cases are discussed. It is informative to see the dynamics of group practice at work during these sessions. When one is surrounded by a group of well-trained individuals, all of whom want to see each other succeed, it is amazing how much help is provided sometimes from the least expected sources. After these discussions, staff members give a prepared paper in weekly rotation. From time to time, outside speakers with particular interests are invited to address the group.

After the first six months with the Clinic, each physician is entitled to semi-annual attendance at a one-week postgraduate course with expenses paid.

Four times a year, the Clinic publishes a Proceedings. Although as yet this has not shaken the academic world, at least it means that, again in rotation, an article is prepared. This also makes the preparation of the paper somewhat easier because, in our experience, unless there is a deadline to be met, somehow it is exceedingly difficult to get a paper finished.

Through a library fund, desirable periodicals are obtained and selected books are purchased.

Beginning this fall, by arrangement with the Albany Medical College, two-way radio sessions will be held during the week at regular intervals allowing physicians to participate in these symposia. All area physicians will be invited to join these teaching sessions.

An active research program is carried on, which, it is felt, inevitably encourages a higher level of medical care. The current major effort is a study of aggressive behavior of third-grade school children and their families in Columbia County; but we have also carried out clinical research programs from time to time. For instance, we are currently making a study of epiphysial fusion in the 5th metatarsal.

In rotation, we try to see that most of the conferences within a reasonable distance are visited by a staff member, after which the visitor makes a report at one of the Thursday evening meetings.

In addition to this, staff members hold faculty positions at the Albany Medical College, Smith College, Seton Hall Medical School, and Yale.

Last year, staff members were asked to lecture in nine different medical schools. In addition, papers were read at fourteen conferences.

DISTRIBUTION OF SPECIALTY SERVICES.

The Clinic has established six area offices during the past eleven years in those parts of the county where there has been a need or opportunity for replacement of physicians. The first of these was established in a town 19 miles down the road. This was a town which had formerly been served by three doctors, then two, but for three years had been able to attract no one. A subsequent area office was established in a town 12 miles away when one of the two doctors suddenly died; a third in a town 14 miles away when one of the two doctors left; a fourth at the request of the Town Board in a town 21 miles away; and just recently two more area offices have been opened — one 16, and one 14 miles outside of Hudson. This leaves one area uncovered, but currently there is not enough population in this part of the county to support the establishment of a facility. When fully staffed, the resident team in an area office represents internal medicine, pediatrics, and dentistry.

The First Fifteen Years:

A Possible Solution to Some of Rural Medicine's Problems

Caldwell B. Esselstyn, M.D.

Fabian Bachrach

This is supplemented by a visit from an ob-gyn man a half-day each week, and a surgeon a half-day each week. Through this mechanism the community will eventually have very few people more than five miles away from a Rip Van Winkle office where they will have made available the services of a Board-qualified specialist in the basic fields of medicine, surgery, pediatrics, obstetrics, and gynecology, as well as dentistry. For further services it is necessary for people to come to the central office in Hudson, which, however, is not more than a comfortable 35 minutes from the most distant area clinic. It should be emphasized that physicians in the area offices hospitalize their own patients.

THE CLINIC AS A COMMUNITY AGENCY.

From the onset, the Clinic has felt that it could be most effective in helping people become aware of their medical responsibilities by integrating with other community agencies. It has attempted to do this in several ways:

work being carried on in this area. This has developed into a Health Education and Welfare Council.

The Clinic has provided a Mental Health Team consisting of psychiatrists, psychologists, sociologists, and psychiatric social workers whose services are available throughout the county. This team has been requested by the New York State Department of Mental Hygiene to assume responsibility for the psychiatric care of Welfare patients, and for responsibility for what was formerly the Traveling Child Guidance Clinic. For several years the Clinic made available to three of the school districts services of a psychiatrist, clinical psychologist, psychiatric social worker, and health educator. As a result of this, three of these school systems now have their own full-time clinical psychologist.

Through an arrangement with the Department of Mental Hygiene and the State Board of Education, classes for minimal-brain-damaged children have been instituted.

Members of the Clinic staff have worked closely with the School of Nursing which is associated with the local hospital, functioning as teachers.

Several years ago, the Clinic made available to the

Photos by Rowles Studio

Germantown area office

Philmont area office

Each year for the past several years one of our internists has been sent to the New York State Health Department Course and become qualified as a Grade II Health Officer. For the past several years, in addition, one of the internists in the Clinic has functioned as the Deputy Commissioner of Health in the county. A third member of the Clinic staff has served on the Board of Health for several years.

In 1947, the Clinic established the first Cancer Detection Center in Upstate New York, which it carried on for exactly ten years. From this experience, the Screening Examinations which are now available six days a week were developed.

Some years ago, one of the staff established a County Social Workers' Club in an attempt to coordinate the Arts and Crafts League a large building formerly used as a carriage house and garage. It is hoped that as programs develop it may be the nucleus of a day-care center.

Staff members have been active in helping the Volunteer Rescue Squads with their First Aid work.

For several years the Clinic has made available the services of a health educator, and classes are currently being held for expectant mothers.

Several times each year there are educational meetings for subscribers to the Health Insurance Plan of Greater New York and their friends.

The Clinic staff played an active role in the organization of the Columbia County Conference on Youth which

was sponsored by the Columbia County Social Workers in cooperation with the New York State Youth Commission.

Through volunteers, a monthly exhibit of some kind of local handicraft is shown in the waiting room of one of the area offices. This has included jewelry, painting, ceramics, sculpture, weaving and carpentry.

The local Garden Club in one area has provided foundation planting for the medical building.

The Clinic facilities are made available to the voluntary agencies and Department of Health for special meetings or clinics.

WHOLE MEDICINE PAID BY A SINGLE PREMIUM.

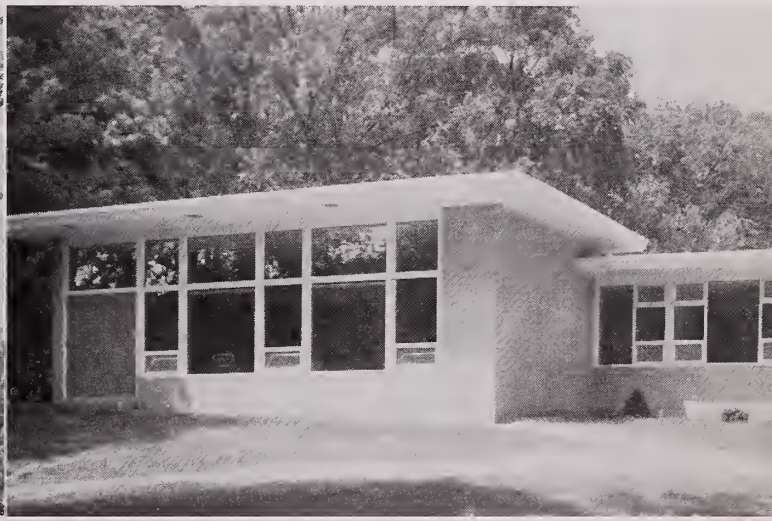
Although the great majority of payments for services is still on the conventional fee-for-service basis, the Clinic also supplies the services to certain institutions on a contract basis. From the onset, it was the hope that the Clinic might some day make available to the people of Columbia County an opportunity to budget the entire cost of their professional medical care through a direct service prepaid plan. Accordingly, some years ago an affiliation was achieved with the Health Insurance Plan of Greater New York. With the exception of one or two small groups, all of the subscribers to this plan have been enrolled on an individual basis. Currently, the total enrollment is slightly under 1,000, but the growth of the plan is wholesome. If the staff can learn to care for patients within the framework of this relationship, and if patients on the other hand enjoy this opportunity of being able for the first time to budget the entire cost of their professional care by paying for total medical care on a flat fee basis, the number of subscribers will grow; if not, the plan will wither on the vine. In either case, it is an important research program in itself which, to date, gives every promise of substantial growth. The Clinic views with enthusiasm the potential which the further development of it will provide for making truly comprehensive care available through this mechanism.

It becomes obvious that in order to provide comprehensive care, especially in rural areas, it is increasingly important that there must be an orderly integration of the pattern of patient referral for various specialty services. As long as a community is served by isolated, competitive, solo practitioners, each of them referring their cases in need of specialty care in all directions, there will never be enough volume of cases in the more limited categories to justify the support by the community of qualified specialists in such fields as urology, orthopedic surgery, etc. The more sparsely settled the community, the more important this principle. It is hoped that over the years as the caseload of the Clinic grows, full or part-time specialists will be available in an increasing number of fields.

During these first fifteen years the Clinic has established the physical plant and organizational structure which make possible a truly integrated community approach to the medical care of this rural county. A final area office must await further population growth. A new Clinic Medical Center is urgently needed in Hudson and represents a fascinating opportunity. The opportunity lies in developing an ideal rural community health center. This spring, the Yale School of Architecture and Design assigned the drawing of plans for this clinic building as a project to the Senior Class. Some very stimulating ideas resulted.

The day has gone by when public health should be on one end of town and private health on the other, or public health in one building with the community Welfare Department disassociated both physically and spiritually. A rural community can least afford to support separate

Foundation House — the home of the Research Team



Canaan area office

offices for the various voluntary agencies such as Cancer, TB and Health, Diabetes, and the many other private agencies. The intercommunication between these disciplines which would be encouraged by making offices available in a single building would be of tremendous value.

During these first fifteen years the Clinic has also been developing the nucleus of a permanent staff after an initial shakedown cruise. Nineteen of the staff members have bought or built their own homes and settled in the area. Our full staff now consists of ten internists, three surgeons, one of whom in addition has his Boards in Chest Surgery, one part-time urologist, one full-time OB-GYN man, two pediatricians, one part-time radiologist, one part-time ophthalmologist, one full-time optometrist, four full-time dentists, one part-time orthodontist, one full-time physiotherapist, two psychiatrists, two psychologists, two psychiatric social workers, and four members of the research team comprising three Ph.D.s and one M.A.; a part-time health educator, and finally, perhaps the most important of all, an administrator.

One of the areas for development in the future lies in the field of education. Although the Clinic is not in a position at the moment to carry on formal teaching at the medical-school undergraduate level, it is rapidly reaching the stage where a Fellowship Program for those interested in comprehensive rural group practice might be very rewarding for men who have had at least two years of internship or residency. We have come to learn that no

Rowles Studio

Hudson Central Office of the Rip Van Winkle Clinic

matter how many years of formal training a physician may have had, there is much to be learned when actually beginning practice. To be able to acquire this learning within the framework of a team which wants to see each member succeed, is actually one of the advantages offered by group practice. Men completing a one or two year Fellowship of this sort would be in great demand in other rural groups or in the rapidly increasing number of areas where communities are organizing their own comprehensive direct service plans.

The development of some kind of an organized home-care program is another area which must be developed in the years ahead. The time has come when hospitals and institutions should not be looked upon as the last word, but rather the last resort. It is being ably demonstrated that in properly selected households the chronically ill and the elderly can be beneficially maintained at home in familiar surroundings amid normal living conditions.

The growth and development of the Rip Van Winkle Clinic to date has been a measure of the extent to which an integration of the specialization of medicine on a community-wide basis has been acceptable to the people of a relatively poor rural county, and the degree to which well-trained physicians and their families have elected rural group practice as a way of life.

An attempt has been made to answer some of the problems of rural medical care which the country must face in a realistic way in the very near future.

Neefus

The first Health Insurance Plan subscriber: A demonstration of how a farm family can pay for total medical care on a flat fee. This farmer added an extra stanchion to his herd and from the income of his "HIP cow" he now is able to meet his known medical care budget.

Berlioz and the Boston Symphony Orchestra

Opinions of a Dissenter

Robert Hayes '59

Dr. Hayes is House Pupil in Neurology at the Massachusetts General Hospital

Boston, our rather staid and self-satisfied city, loses at the end of this year Dr. Charles Munch. This causes many of us to stop and consider our loss, which is considerable, and even more to look at our musical environ.

Dr. Munch was early in his career an experimenter, who remained devoted to his ideal — that of presenting the music of France with the brilliance and verve that he and few others could master. I vividly remember him conducting Roussel in Paris in the early 1950's, and at that time I became a disciple; the flashing tempo, the stringent — almost blaring — brasses, the unequalled woodwind choir, and most striking of all, the blending of the orchestra under the flawless drama of his conducting. Through the past ten years my admiration for Dr. Munch and the Boston Symphony has not waned, yet there are certain points I would like to make, and I know no better way to present them than to ramble a bit about Munch and Berlioz.

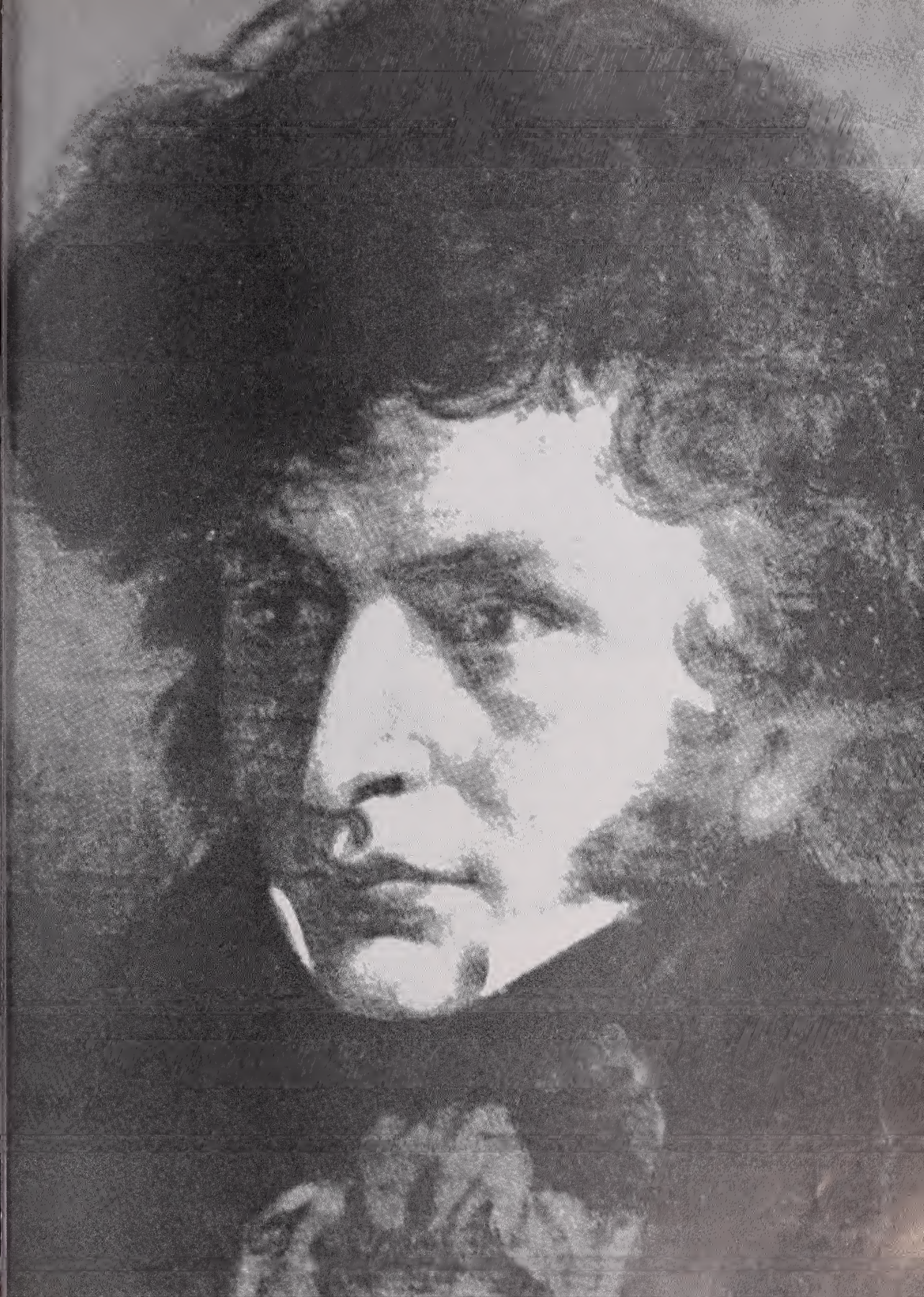
It is well known that most music-lovers would have only Munch's Berlioz, the same way one might prefer Casadesus' Debussy, or Walter's Mahler, Toscanini's Beethoven, Brailowsky's Chopin or Beecham's Haydn. Berlioz was the forté of the B.S.O., the music people came across the United States to hear, and the music that has struck the deepest into the musical consciousness of most of us.

Dr. Munch never failed to bring certain of Berlioz' works to us every year. One might expect to hear each season the *Fantastic Symphony,* the Second or Third Symphonies *(Harold in Italy* or *Romeo and Juliette)* and often the oratorio, *L'Enfance du Christ.* Almost yearly we began to expect the *Requiem,* with brass choirs perched like figures in a Gothic cathedral in the garish Baroque of Symphony Hall. To someone from St. Louis or Dallas this would be more Berlioz than would probably be presented during their lifetimes, but was it much for the Boston Symphony?

Never once, for instance, did we hear an entire Berlioz concert. How often have we heard that fiery meteor across the Paris sky of 1850, the *Te Deum?* It is doubtful now that we shall ever hear the *Symphonie Triomphe et Funerale.* Could we not have had symphonic excerpts from the operas *Benvenuto Cellini* or *Les Troyens?* Will the Metropolitan Opera ever cease with the Italians and give us this last opera, about which Berlioz said: "the completion, the end of my Thirty Years' War against the routineers, the professors and the tone-deaf."?

These works are difficult, and require large orchestras and choruses, yet music-lovers will devote time, money and effort to producing that tintinnabulous concoction, *Die Ringen die Nibelungen.* As usual Shaw was right when he remarked that it was a good thing that the more demanding Berlioz was not produced more often, since it was generally so poorly done. Still if the Boston Symphony dares not produce these works, can we hope for their production in the United States in our lifetime? Under his baton: a concert with the Boston Symphony,

Painting by Signol, 1832. From *Berlioz and the Romantic Century* by Jacques Barzun, Little, Brown and Company, 1950.

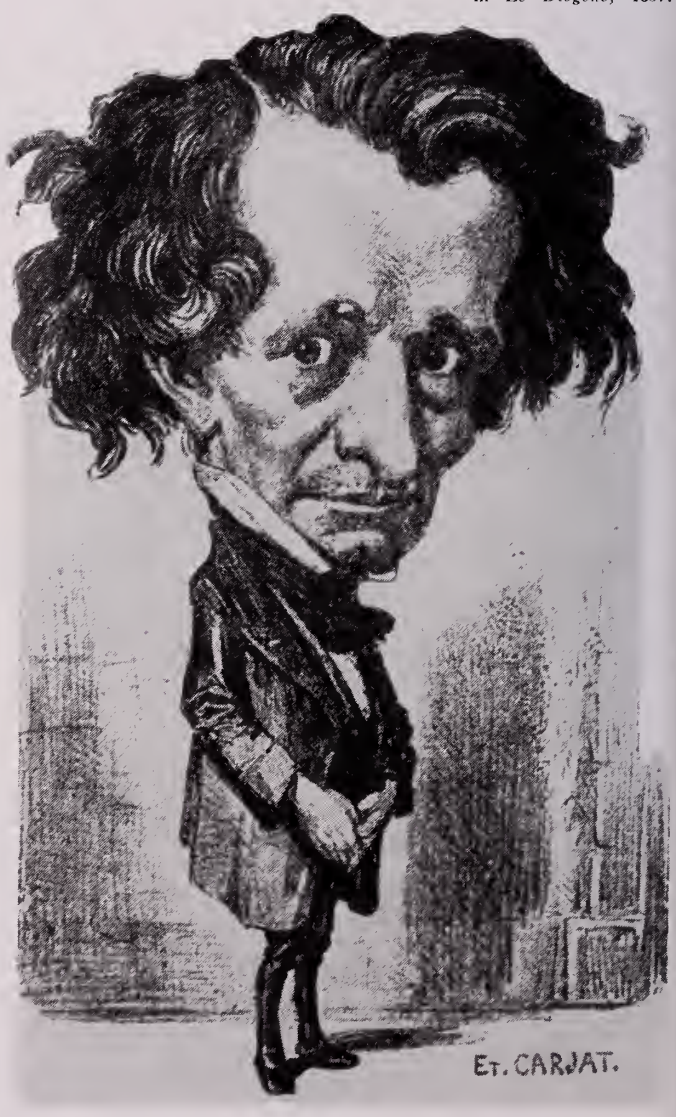


the Harvard-Radcliffe Choral Society, combining with the Chorus Pro Musica, the musical faculty of the New England Conservatory of Music, and the interested from our many educational institutions? Then with an orchestra of four hundred, a brass choir of 120, thirty pianos and a singer to match each instrumentalist: ah! the pleasures of fantasy!

Every generation looks backward when peeved with what it finds about itself. In the eighteenth and nineteenth centuries, a different attitude existed toward the concert. The menu was often sparse, and the orchestras were tempestuous, the audiences demanding and capable of expressing intelligent opinions about music. The only thing that will make an orchestra tempestuous now is the contemporary wage scale, which gives profit and monetary success to the least skilled. Our audiences will suffer through concerts for the blessed intermissions and the post-exhaustion brandy and cigar.

Even if we accept disinterested orchestras and the bloated tone-deaf that make up our audiences, we still have concerts composed of Italian overtures, followed by Romantic tone poems, interspersing a few minutes of cacophony to wake up the over-fed, closing with an acceptable classical symphony. When all London flocked to hear Haydn under the aegis of Salomon, when the Germans flocked to Baden to hear Berlioz, when the cosmopolites of today flock to Salzburg (should we include Bayreuth?) — they went to hear music, not potpourri!

Caricature by Carjat in *Le Diogène*, 1857.



One hundred years after it was written, Berlioz' music is to some a combination of noise and musical flamboyance. This is largely because the *Fantastic* and the *Roman Carnival Overture* have become war horses, played over and over. Brooks Atkinson once said that "in my library the supreme masterpiece is *L'Enfance du Christ*." Most of us have good reason to be sad, for how can we fathom the range of Berlioz' writings when we cannot become acquainted with them? Perhaps this is why he remains the most misunderstood of the nineteenth-century composers. Jacques Barzun in his masterly biography of Berlioz brings his life and times into such intense light that these volumes, like Sullivan's *Beethoven,* should be in every music-lover's library. Barzun writes with the entertainment of a Maurois, incorporating life in the Napoleonic and early Republic into Berlioz' life, almost taking up the drama where Thomas Carlyle leaves off.

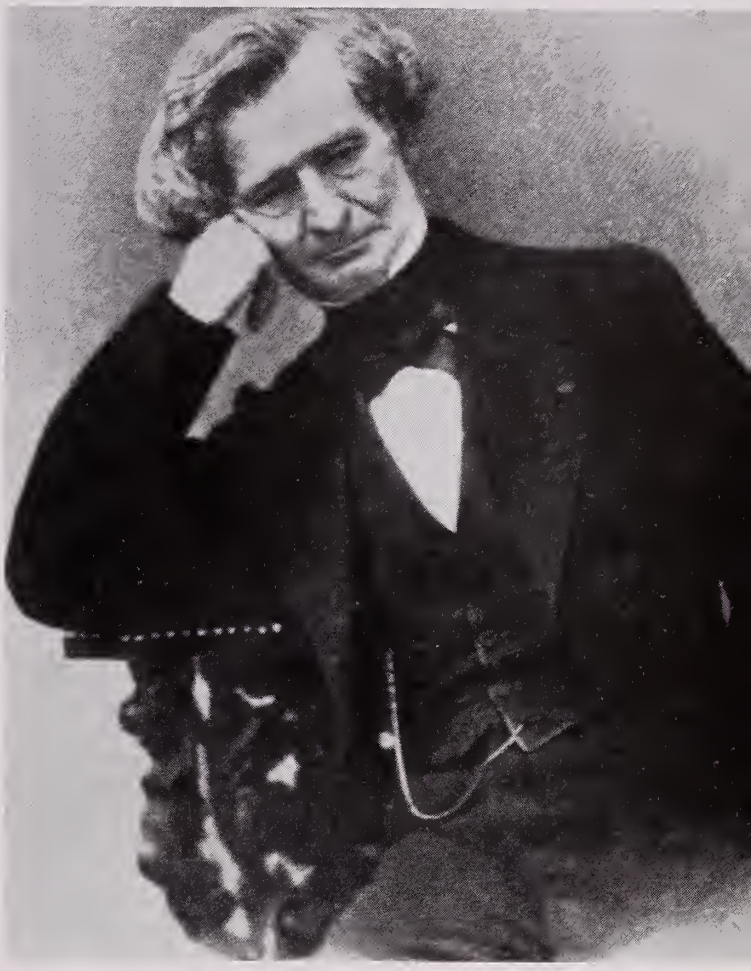
Berlioz, the aristocrat, polite and scholarly gentilhomme, the lover whose affairs are still notorious, the composer and conductor and critic, the man who by preference created no school; the musician who with each major production changed direction and purpose leaving his contemporaries floundering after him; the eclectic rebellious figure, the apotheosis of the Romantic Movement, who would rally no followers and cared not

a farthing for anything except his art. So much like Franz Liszt, yet having genius. Liszt is worth noting in that he encouraged Berlioz in the 1830's and 1840's, but finding no philosophy and no protocol, Liszt turned to that most philosophical of musicians, Richard Wagner, who preached the merger of drama and music into a sort of historical-cultural-Geist-drama.

Being prolific by nature, Wagner succeeded in producing a vast quantity of this philosophical drama. But Berlioz and Wagner, due to personality differences, and even more to their differing conceptions of the artist as composer, were doomed to pursue separate paths. This was inevitable as long as Wagner excited more and more noisy followers, and his music-dramas became feats of endurance for singers and audiences. One understands why Wagner is done in daylight at Bayreuth, it is day-music. The night is for lovers, madmen, poets and Berlioz addicts. The Bayreuth festival remains our prime example that people are willing to be bored if they have something to believe in, and quite as unwilling to be stimulated if they do not know what to expect.

Berlioz' only true school of followers were the Russians, and they admitted to no formal heritage. The Russian past so dominates the writings of Rimsky, Cui, Borodin and Mussorgsky that one might not see how heavily they lean upon the principles of harmony and composition established by Berlioz. Aiming for Berlioz's formidable maximum of tone, and trying to achieve his variation in style and his ability to surprise with unusual instrumental combinations; trying for all this yet lacking his secrets, they generally degenerate in frenzy. The true successors to Berlioz remain Mahler and early Bruckner. The second and third movements of the Mahler *First Symphony* carry on Berlioz' belief that the orchestra can and should create musical magic!

The masters of Berlioz were Gluck, Beethoven and later in his life, Mozart. Beginning with his days as erstwhile medical student and continuing until his last critical review for the *Journal des Débats* was written, he studied, produced, rewrote and praised the work of Gluck. One of his great feats was teaching the Parisians the wonder of Gluck. Accustomed as they were to Meyerbeer and Rossini (who was actually called "the Italianate Handel"), this was difficult indeed. Between fighting the impresarios, who were just in the 1850's learning to give the populace "what it wanted," he opposed the academic music of his time which was largely controlled by that Italianate Parisien, Cherubini. While battling these two enemies, and then Cherubini's successor, Meyerbeer (who was so praised in his lifetime that his reputation has subsequently suffered), Berlioz managed to write his music. He thought that the future would produce much of his fame; certainly Paris in the middle of the nineteenth century wasn't ready for his music. Yet, one hundred years later it remains unheard. Out of this era, Wagner could write to Liszt about himself and Berlioz: "At the present moment, only we three fellows really belong together,



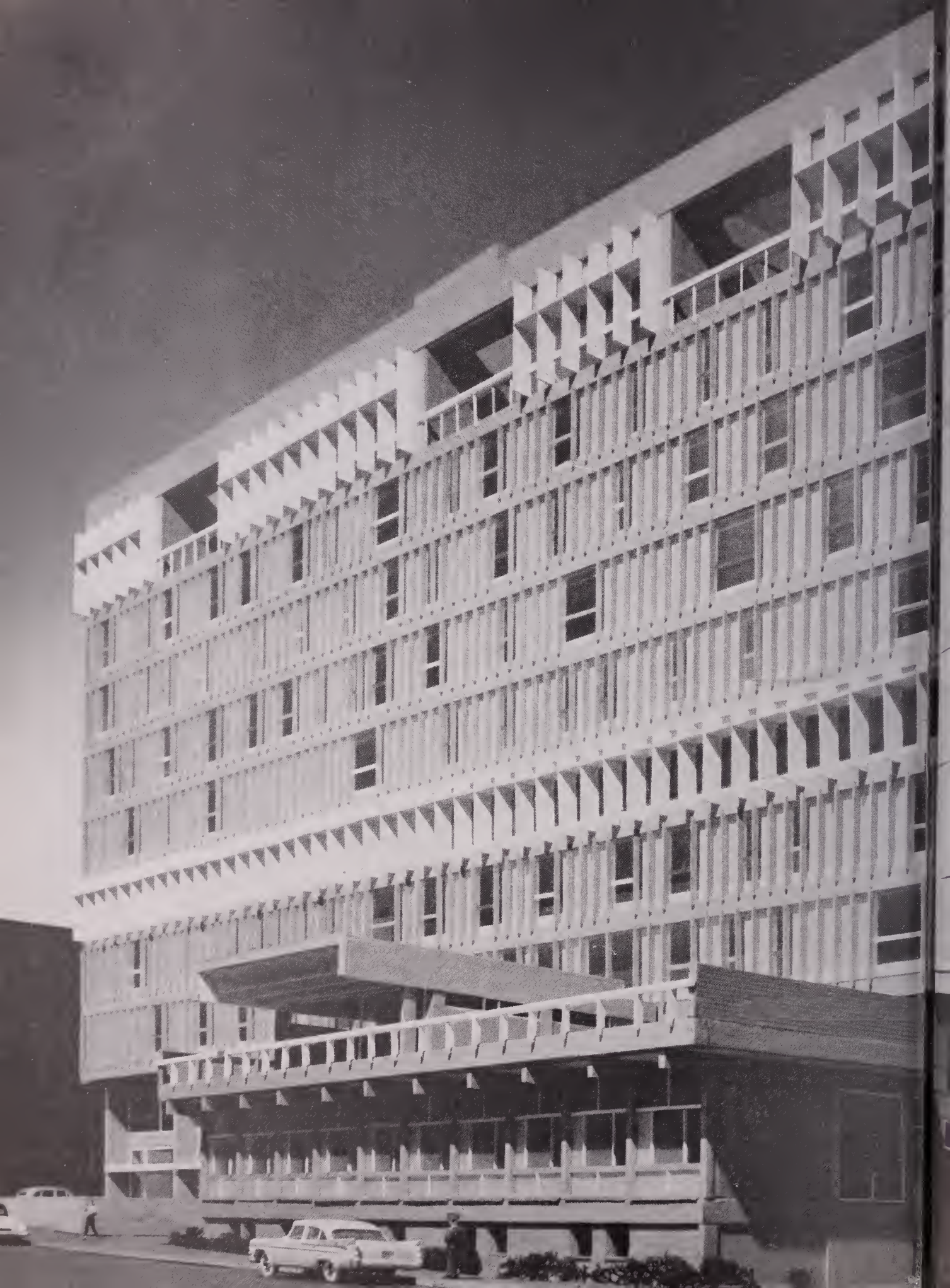
Phot. Pierre Petit

Berlioz in 1863

because only we three are equals, and that is — you — he — and I." Liszt has died, Wagner probably shall, but let us resuscitate Berlioz!!

What a legend. "An orchestra of 467 players, 30 of them pianists!" Our mistake is thinking that this is the whole legend! It is also that of some of the most lyrical and melodious music ever written. This legend is one suited to a serious musical center, with conductor and orchestra. Berlioz' music, if done by the unskilled and disinterested could produce such a blasting and thumping that it might literally bleat the gods off Parnassus. Given the proper orchestra, the proper audience, the heritage of Berlioz remains a forbidden pleasure, an oft-sought and never fulfilled desire for the best music of the Romantic Movement.

His music is difficult and elusive of performance. Only consummate skill can be used in approaching his major works. Shaw knew that a weak orchestra with a strong Berlioz score only damages Berlioz and pains the listener. It is because we have such an orchestra here in Boston, and an orchestra trained in the French tradition, that I make this plea that the Romantic Movement have a rebirth, a rebirth waited for these past years in vain.



HEALTH FOR HARVARDIANS

Curtis Prout '41

Chief of Medical Services and Associate Director
Harvard University Health Services

Just as H.M.S. is keeping the pot boiling with new construction on the Boston side of "The River," so the parent university in Cambridge is cooking medically. The two major developments are the soon-to-be completed Health Center building on Mt. Auburn Street and the already-in-operation comprehensive prepaid medical care plan.

THE BUILDING

One of the first objectives of the well-publicized and highly successful Program for Harvard College was the establishment of a new Health Services Building. Actually, the planning started in the autumn of 1954, the impetus coming from the retiring Henry K. Oliver Professor of Hygiene, Arlie V. Bock '15 and his successor, Dana L. Farnsworth '33. The plans and need for the health center preceded the fund-raising plans. Preliminary sketches of the building were available during the drive and the plans were completed by José Luis Sert, Dean of the Harvard School of Design and his associates.

Now housing Health Services on the first five floors and two basement levels of the T-shaped streets in Cambridge, the building eventually is to be completed with a matching T fronting on Massachusetts Avenue. Ground was broken on February 17, 1960 and the Health Services portion was to open with the College this fall. Unfortunately, the familiar woes of building descended in greater numbers than usual. Among these was an unhappy and fatal accident involving the spontaneous rupture of an apparently sound and previously inspected steam valve. Then came the usual seasonal, and some non-seasonal, strikes of various building specialists. Hopefully by the time snow flies, the basement through the fifth floor of the new Holyoke Center, as the whole building will be called, will be in operation. The rest of the building, which will be devoted to various administrative purposes of the College, will probably be completed before Christmas. (The accuracy of this prediction depends largely on the uncertainties of New England weather.)

The magazine *Architectural Forum* in September, 1960, cites the new building as an example of jazz in architecture and says,

> "This one is interesting, because the process of creating the more jazz-like rhythm for the façade can be traced (in the evolution of the plan) from a front divided into eight bays by the columns of a conventional grid system. These columns

still peep through in places in the later model where the façade has been treated with a jazz idea. This is a fairly sober architectural jazz befitting its Puritan surroundings and it deviates from jazz altogether in the fact that the façade has a frame all around it."

As the building has gone up, every viewpoint has been expressed and whether it is jazzy or puritanical would appear to be a matter of individual opinion.

In the basement are an emergency entrance with an operating room, a large x-ray suite planned by and for Dr. Richard Schatzki, a large physiotherapy room, a kitchen, a central supply room, and quarters for the residents who stay overnight and on the weekends. On the street floor is the main clinic. By ingenious and attractive placing of reception areas, and examining rooms, as many as fourteen doctors and three or four nurses, with a well-equipped laboratory, can accommodate as many as one hundred ambulatory patients at a time. We hope this eventuality will never arise, but even if it does, it is not likely that this area would look crowded. Aided by its colorful decor and ingenious lighting, the Health Service is determined to avoid both the semblance and the reality of a large or impersonal clinic.

On the second, third and fourth floors are a good-sized medical library in memory of the late John P. Monks '28, a smaller specialized library and reading room in honor of Dr. Bock and the most modern of record rooms. There are individual offices for the chiefs of service, and for various specialists. In one section, Drs. Daniel Funkenstein and Stanley H. King direct a research unit which has been engaged in a wide variety of studies on normal and abnormal conditions in the student population. It should be re-emphasized here that none of this research is paid for by any of the insurance or other health fees from the patients. It has also been a matter of special concern of the University Health Services that no research be done on undergraduates at Harvard without adequately considering the safety of the student volunteer.

Also on the fourth floor is the Environmental Health and Safety Unit directed by Benjamin G. Ferris '43. This division is charged, among other things, with the ultimate supervision of the almost 100 projects within the University having to do with radioactive materials. It is also in charge of studies in accident prevention and safety control in the dormitories, classrooms and laboratories and is responsible for the supervision of the health and sanitation in University eating places. Dr. J. Carroll Morris, Gordon McKay Professor of Sanitary Chemistry, is Sanitary Inspector to the University Health Services.

The Bacteriology Laboratory will also be in this unit. The rest of the clinical laboratory will be operated under Dr. Bradley Copeland for Dr. Shields Warren's Deaconess Hospital group. There are also a large and small conference room, business offices and space for the Faculty and Employee Health Survey Unit which does routine checkups for any patients who wish them. There is an attractive dental prophylaxis and examination suite

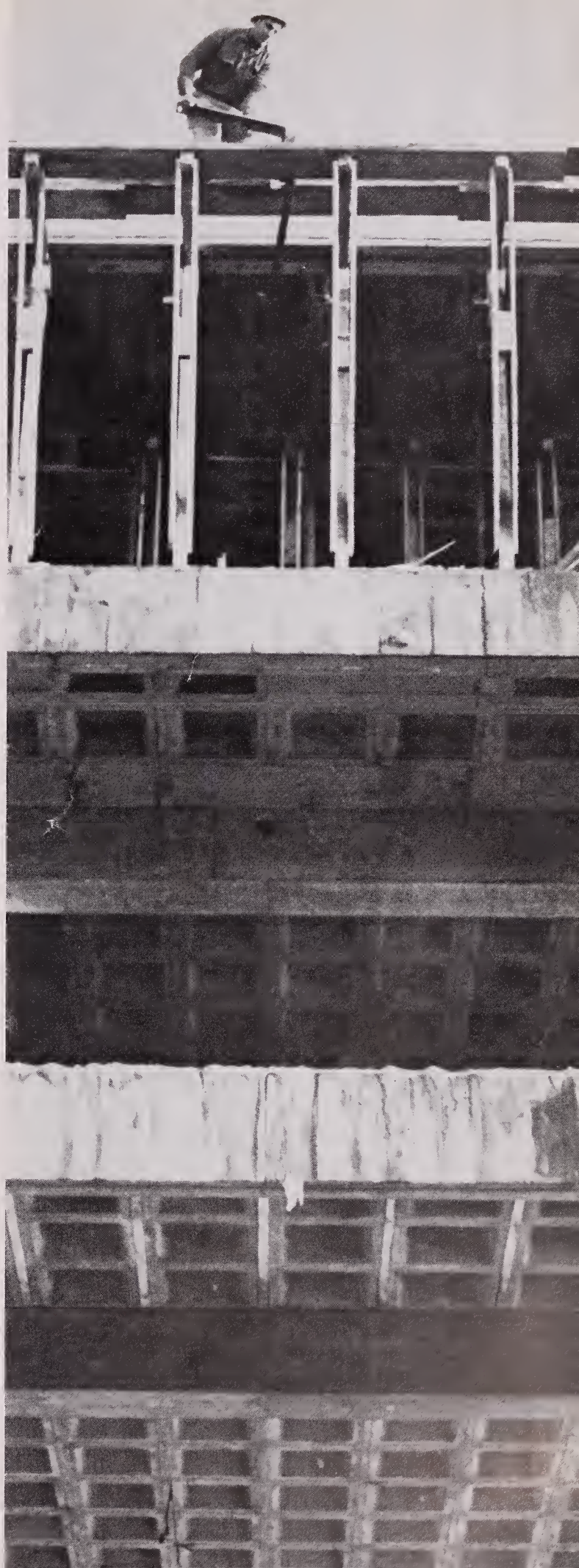
in which the present diagnostic and emergency facilities can be greatly expanded as needed.

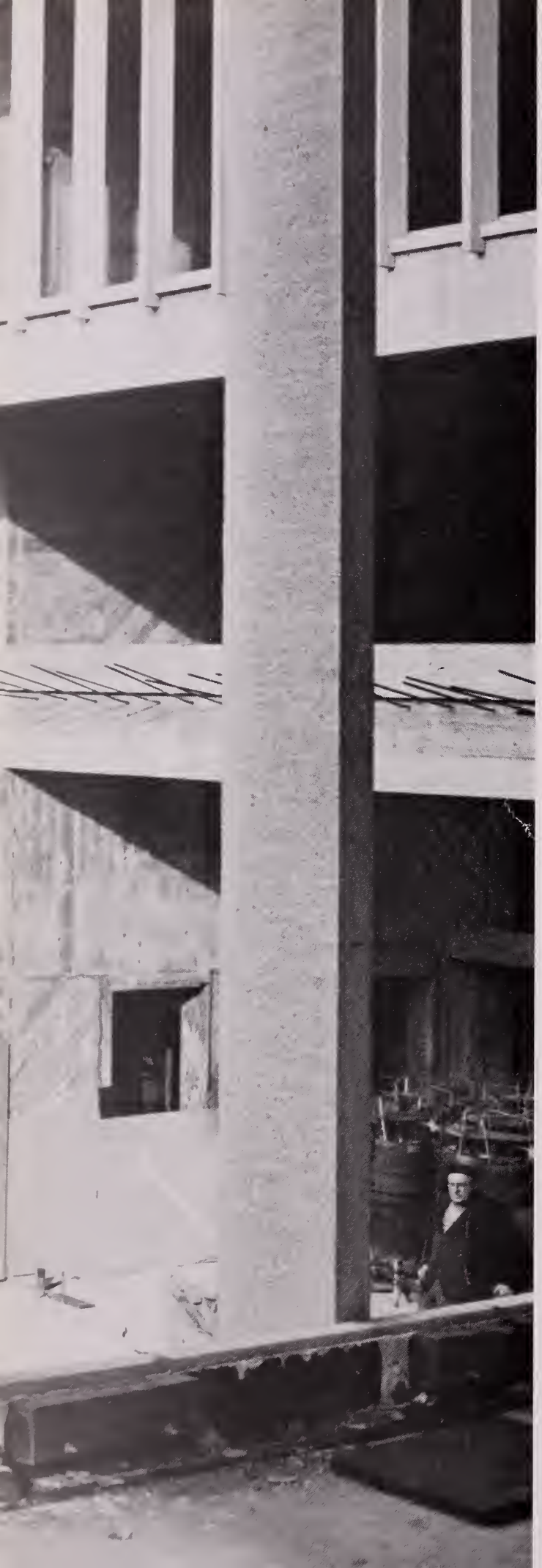
The crown, so to speak, fitting geographically and perhaps medically on the top of this building-within-a-building, is the new Stillman Infirmary, which will occupy the entire fifth floor of this unit of the Holyoke Center plus an overflow unit on the fourth floor. Replacing the open wards of the old Stillman Infirmary (whose fate is still undecided) will be single and double rooms, each with its own toilet and wash basin and all air-conditioned, as is the entire building. Reflecting the latest developments in hospital design, these rooms have all the most recent improvements in communication, control of infection and efficient distribution of nursing care.

The relation between this infirmary and Harvard Medical School is informal but real. In the first place, students, faculty and employees of H.M.S. will be eligible for hospital care there. It is not anticipated that we will handle any major surgery or major medical diseases, which would require the services of a blood bank. Such cases will be taken care of, as in the past, at the Harvard teaching hospitals. However, we contemplate such innovations as early post-operative transfer of students from the large teaching hospitals back to Cambridge where they would be close to friends and would be in a small hospital primarily concerned with the care of the patient, rather than the famous Harvard triad.

Stillman Infirmary sees many illnesses rarely seen at H.M.S. teaching hospitals, the common contagious diseases such as measles, mumps, chicken pox and mononucleosis; it is therefore unique as a teaching pool. The new Hospital, in other words, would complement rather than compete with the large teaching hospitals. There are cases where patients are not sick enough to be sent to a large general hospital, but are not under adequate supervision if they are quartered in dormitories away from family and friends. Such cases are frequently held in the emergency wards in the larger hospitals for 24 to 48 hours to avoid many of the formalities and expenses of a full admission. Now they can be efficiently handled in the new Stillman Infirmary.

It has been pointed out that the large general teaching hospitals are built to care for the very sick, the elderly and those with unusual diseases. The University Health Services' population of approximately 13,000 students, 4,500 faculty and 4,800 employees constitute, in general, a younger and healthier group. The new Health Center building is therefore equipped to handle mainly ambulatory treatment and preventive medicine. To care for this group, there are 25 full-time and some 70 part-time physicians. This number may sound large, but it includes workers in the Environmental Health and Safety Unit and research workers not paid by, or directly concerned with, patient care. There are about 20 nurses, 40 secretaries and 40 administrative, technical and custodial workers under administrator Mr. John B. Butler.





To conclude any discussion of the new building without mentioning money would be unrealistic and almost un-American. The cost of the Health Services' part of the building is about $4,000,000, or 65% of the cost of the entire structure. The annual budget of the University Health Services is $1,500,000.

THE PATIENTS AND THEIR DOCTORS

Planning for a new building has been a stimulus to much re-thinking on the subject of patient care. The very substrate of our work, the pool of patients, has changed. The evolution has been from a first-aid type of student service to the present comprehensive plan. Harvard has accelerated its expansion over the past seven years. The College Health Service (formerly the "Hygiene Department") in 1956 became the University Health Services and embraced all of the graduate schools, including Radcliffe, in 1957. As of September 1, 1961, a large portion of the faculty and employees of the University came under a comprehensive program which provides prepaid medical care for all, utilizing insurance plans aimed at the varying needs of students, faculty and employees. Those who live within a reasonable range of Harvard and who are ambulatory can have most of their medical needs met, either in the regional medical office (Medical School, Law School or Business School) or in the main Health Center. Specialized consultation services by outside doctors are covered by the student plan if the patient is referred by the U.H.S. Dependents are not eligible for care in the new building, but their medical expenses for outside hospitalization, surgery, and medicines are covered within broad limits, and any illness treated at home is covered after a small semi-annual deduction. Illnesses occurring to subscribers or dependents away from the Boston area are covered. A special arrangement with the Boston Lying-In Hospital makes it possible for students' wives to have obstetrical care at reduced rates.

The Faculty and Employee Medical Plan, including Blue Cross and Blue Shield, is principally paid for by the University in the form of a tax of 2% on the payroll of each Department. This 2% does not come out of individual pay checks. Half of this money covers the medical services performed at the Health Center, and the other half goes toward the insurance. In addition, each faculty and employee subscriber contributes $36.00 per year for individuals (2600 of these) and $96.00 for families (3500 families). The student pays $54.00 a year to cover the Health Services and Infirmary, plus $20.00 for year-round insurance.

Many M.D.'s feel they should be exempt from such plans because of "professional courtesy." The problem of who should pay for the medical care of the large community of non-practicing doctors has always been a difficult one. Over the years, the "doctors' doctors," our H.M.S. favorites, have borne a tremendous burden without outcry. Now, these men can be rewarded in part

through prepayment plans which also cover doctors in the Medical School area. Human nature being what it is, the doctors' doctors should now be even happier to take on the care of colleagues and their families. For it is a fact that the better the doctor, the greater have been the demands on his free time. Usually, these men have already given considerable valuable time to teaching and research. Their reward has been to be asked to give more time in the care of their colleagues. This has helped to lighten the burden on the doctor's wife who must buy expensive, elusive and frequently unwelcome Christmas presents for "professional courtesy" services. An interesting finding in the first two years of the Harvard insurance plan, incidentally, is that hospital admissions were 26% less than for any similar group plan in Massachusetts and among those hospitalized, the average stay was only three tenths of a day longer.

SOME PROBLEMS

Naturally, the delivery of medical care to this large number of people raises many questions, mostly relating to problems common to all medical-care programs. We hope we can find some of the answers. One obvious and continuing problem is providing the patient with the doctor of his choice, but at the same time providing the patient and doctor with the best sort of consultation and laboratory support. Much as we would like to make the patient feel that the doctor he gets is his own, it is manifestly impossible to have any one doctor perpetually present, otherwise unengaged, and omniscient. Also, to give all-out laboratory services covering every diagnostic point will make the plan too expensive and the question comes up of where to draw the line.

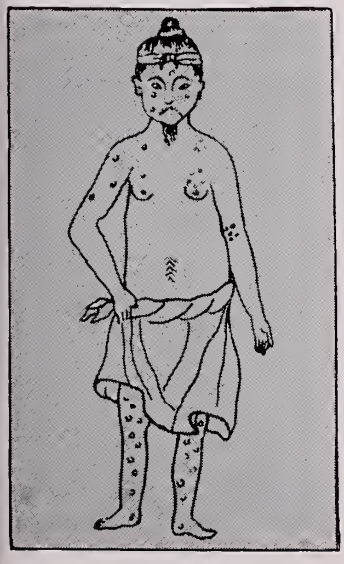
Another challenge is to attract, and hold, well-qualified physicians and surgeons. Again, can we, within the income provided by insurance, help them to practice the way they want, and at the same time continue their education? If we don't urge everyone to make appointments for non-emergency complaints, how do we handle the people who feel that doctors make themselves inaccessible? If we now make employees of Harvard feel that we can be their doctors, what will happen to the excellent relations Briant Decker's '30 clinic has developed among the University, its employees, the insurance companies and the LMD's? What are the proper intervals for checkups at various age levels, and what should be the minimum extent of the periodic checkups? How much time should the psychiatrists give under such a plan in assessing and treating emotional disorders whose roots antedate any connection with Harvard? What time and money should we properly spend in the prevention of illness and accidents? What surgical and other procedure should be reimbursed on a fee-for-service basis?

If the solutions to just a few of these problems are found, we shall literally as well as figuratively make a step toward fulfilling the Biblical injunction, which might well be applied to our profession: "Set thine house in order."

Syphilis Sive Morbus Gallicus

Syphilis as it first Appeared in Western Civilization

Graeme Hanson '62



THE Renaissance gave birth not only to such men as Leonardo da Vinci, Michelangelo, Cellini and Paracelsus, but also to the most insidious and devastating venereal disease ever to afflict mankind: Madame Syphilis. Few diseases have run the course of this pestilence, which appeared suddenly in southern and western Europe at the end of the fifteenth century and ultimately involved all of society and the whole fabric of moral and social attitudes of the Renaissance.

The milder forms of venereal disease had been well known in Europe for several centuries before the appearance of syphilis. Celsus described a disease of soft chancres or ulcers which was probably chancroid, and our present-day gonorrhea was differentiated from the other -rheas already in the thirteen hundreds and given the name *chaude pysse*, a more apt and descriptive name, by the way, than our present colloquialism. With the advent of syphilis, the classification of venereal disease suddenly fell into confusion once more.

There seems little doubt that syphilis was first recognized as a definite disease in Europe at the time of Columbus's return from the Indies. When Charles VIII of France "invaded" Italy and Naples in the late 1400's, his campaign resembled a leisurely walk through the Italian countryside, with ample time for delightful debauch and pleasures for the band of mercenaries which he had gathered from every country in Western Europe. While preparing to occupy Naples, however, a plague of such virulence broke out that it forced the dissolution of the army and the return of the troops to their various homelands. As they traveled homeward, these soldiers carried with them the new disease which the Italians, assuming an insight into Gallic temperament, named the "French Disease" or *Morbus Gallicus*. The French naturally preferred to call it the "Neapolitan Disease!"

Even though horse and ship were the principle means of transportation in sixteenth-century Europe, travel among the various states was extremely active, and so, in consequence, was the spread of syphilis. Within a year of its appearance in Italy, it had spread to France, Germany, and Switzerland. In 1496, Holland and Greece noted with horror the appearance of spotted palms and soles among their populace. By 1497, it had spread to England and Scotland and, by 1499, to Hungary and Russia. The town council of Aberdeen in 1497 proclaimed that

> "for protection from the disease which has come out of France and strange parts, all light women desist from their vice and sin of venery and work for their support, on pain else of being branded with a hot iron their cheek and banished from the town."

The disease attacked not only "light women," but reached all strata of society, including the Church. In 1525, Benvenuto Cellini, that arrogant and pugnacious goldsmith of Florence, commended the syphilologist da Carpi by saying: "This able man, in the course of

his other practice, undertook the most desperate cases of the so-called French Disease. In Rome, *this kind of illness is very partial to the priests, and especially the richest of them.*"

Where did syphilis come from? We shall probably never know for certain. The predominating theory throughout the past four centuries has been that the adventurous crew members of Columbus's ships brought it back to Spain with them in 1493. According to this theory, Spaniards joined the army of Charles VIII and thereby facilitated the spread to Italy. Dias de Isla, a physician of Lisbon and Barcelona at the time of Columbus, claims that at least one of Columbus's pilots was already stricken with the disease when the boats arrived in Barcelona and most, but not all, observers of the time felt that the new disease came from Haiti, or Espaniola, as it was then called. Modern-day proponents of this theory have gone to great extremes to bolster their view. Thousands of skulls and skeletons from Europe and Africa have been studied by pathologists (among them Rudolf Virchow) and no syphilitic bone lesions could be found in the pre-Columbian material. On the other hand, skulls from such divers locations in the New World as Peru, Mexico and Tennessee have shown fairly conclusive evidence of syphilitic changes. Another interesting bit of negative evidence is given by William Allen Pusey in his book, *The History and Epidemiology of Syphilis,* in which he suggests that, had syphilis existed in Europe in previous centuries, the writers of the times would certainly have made ample use in their writings of a disease fraught with social implications. One can hardly imagine Aristophanes or Boccaccio avoiding the subject through a sense of delicacy. Later writers, from Cellini right up to Ibsen and Thomas Mann, have found in syphilis ample grist for their literary mills.

The theory of the American origin of syphilis seems to be reasonable and well documented. This theory, however, is opposed by several authors, some of whom deserve mention. Richmond Holcomb and Charles Butler, both of the U. S. Medical Corps and laden with a patriotic love for the West Indies, examined minutely the writings of da Isla and others and declared in the nineteen thirties that several inconsistencies were apparent in the documents; with more passion than reason, they discarded the theory of the American origin of syphilis, and proposed that syphilis existed unrecognized for years in Europe, and that its appearance as a disease entity was coincidental with the return of Columbus from the New World. The initial severity and the quick spread of the new disease, however, speak rather strongly against this theory.

There was at least one very important and influential Italian writer of the time, Fracastorius, who did not adhere to the American origin theory of syphilis, but felt that the disease had sprung *de novo* from the atmosphere. In 1484, he explained, the three great planets, Mars, Saturn and Jupiter, were in conjunction, and after such an astrological phenomenon, a great plague of some sort was bound to appear on Earth. The great and devastating plague of the Black Death had appeared in the fourteenth century after a similar conjunction. Fracastorius believed that syphilis could probably have resulted from the conjunction of 1484. Although this theory sounds rather fanciful to our modern ears, one might argue it along with the other theories, since none has been proved conclusively.

Fracastorius was an exemplary Renaissance man: a great thinker, physician and poet. He wrote extensively on the theories of contagion and therapeutics and was responsible for giving syphilis its enduring name. In one of his better works, *de Contagione,* he devotes three chapters to syphilis and its treatment, and it is interesting to follow his thinking regarding causation and subsequent therapy. To begin with, Fracastorius believed that disease was caused and spread by *minute particles that the eye could not see* and that each type of disease particle had its own viscosity. Because of the site of the primary lesion, the venereal origin of syphilis was not difficult to discover, and its epidemiology was soon well understood. Fracastorius, however, felt that rare cases might arise without contact. If physicians believe all their patients, this phenomenon still occurs today! In describing the mode of transmission, Fracastorius says:

> "It was contracted by contagion, but not from every kind of contact, nor readily, but only when two bodies in close contact with one another became extremely heated. Now this happened in sexual intercourse especially, and it was by this means that the great majority of patients were infected. However, some cases were observed of infants who, by sucking milk from a mother or nurse who was infected, were themselves infected in a precisely similar way."

Unfortunately, most of the therapies were of little avail and were probably successful only in those cases where spontaneous cures would have occurred. The wise physician of the day moved about freely. As Cellini says of da Carpi, "He was a person of great sagacity, and did wisely to get out of Rome; for not many months afterwards, all the patients he had treated grew so ill that they were a hundred times worse off than before he came. He certainly would have been murdered if he had stopped."

Within thirty or forty years of its first appearance, the primary and secondary stages of the disease had been described with extreme accuracy, all the way from the initial hard chancre, to lymphadenopathy, secondary rash (which in the early years took a peculiarly pustular form), gummata, bone and muscle pain, baldness and sores of the mouth and tongue. There seem to be no references to the tertiary, tabetic or paretic stages, however. During the first fifty years of the disease, the initial stage was extremely severe and many people died in this phase.

Nevertheless, most writers comment that by the 1530's, the disease had become relatively mild.

THE origin of the name, "syphilis," has had a great deal of discussion. In 1525, Fracastorius published a rather long poem entitled: *Syphilis sive Morbus Gallicus,* in which he described the first appearance of syphilis in the world in a young shepherd named Syphilis, who was cursed with the disease for having offended Apollo. There has been much discussion concerning the derivation of "syphilis," and some curious and interesting postulations have been put forth. One popular belief is that "syphilis" comes from *sui philus* (lover of pigs), with its most obvious implications. A more interesting variation of this theory is evident when one considers that prostitutes of the day were referred to colloquially as *porcae.* Some Greek scholars propose that syphilis is merely a misspelling of *Sypilus,* a mythological figure, one of Niobe's sons, whose name Fracastorius borrowed for his poem. Fracastorius, however, was a well educated man; moreover, his patron was none other than Cardinal Bembo, the great scholar and humanist. If Fracastorius had been so careless as to misspell the name, Bembo certainly would have commented on such a consistent error. As with the origin of the disease, we will probably never know with certainty the derivation of its name.

Syphilis continued to harass priests, popes and affectionate neighbors with its obvious and condemning lesions. From the 1530's onward, however, the disease assumed the somewhat milder course we observe today. There continued to be some confusion as to etiology and differentiation of venereal diseases. John Hunter in 1707 attempted to clarify the situation by inoculating himself with exudate from a person afflicted with gonorrhea. Unfortunately for Hunter, the patient also had syphilis, and Hunter drew the false conclusion that they were one and the same disease. This bit of self-experimentation not only ruined Hunter's life, but confused the thinking on venereal disease for a good many years.

Successively, with the advent of better bacteriologic methods, Neiver described the gonococcus in 1879; Ducrey discovered the bacillus of chancroid in 1889; and Shaudinn and Hoffman isolated the *treponema pallidum* from a 25-year-old girl in 1900.

NOW penicillin has rung the bell on syphilis, and the physician's only remaining fear is that he has treated the spirochete thoroughly enough so that it does not smoulder on, to break out finally in the dread tertiary syndrome. Although the medical journals have noted of late a new and "alarming" rise in the number of cases of syphilis, especially among teenagers, the incidence is an infinitesimal fraction of its former incidence.

We are witnessing the gradual disappearance of syphilis. Relieved after 450 years of its role as the visible proof of man's social transgressions, syphilis will undoubtedly pass on its duties with ease to bigger and better evils.

Enemy of the People

Paul F. O'Rourke '48

A Modern American Version

THIS story is set in the rich Imperial Valley of California where I have just completed my first job as a public health officer.

In July, 1959, I left private practice in California's wealthiest county, Marin, located in rolling hills just north of the Golden Gate Bridge. In a span of ten years I had built a substantial practice and accumulated a family of six children, five adopted and one of my own. My three girls and three boys include a Hoopa Indian daughter and a Chinese-Hawaiian son.

Why did I leave my practice? I am no different from most of my friends; we all want to be good doctors. To our credit, most of us succeed, but only within the limits imposed upon us by private practice. These limits have bothered me: In addition to the usual overloaded schedule, I am asked to serve as social worker, lab and x-ray technician, health educator, obstetrician, psychiatrist, surgeon, minister, internist; business manager, collection agent, personnel director, insurance agent, and postgraduate student! The development of "good clinical judgement" too often means fathoming which patient with hematuria can afford $150 to protect himself against renal cancer or tuberculosis, and how to spend the patient's money for x-rays not for his benefit but to protect myself from malpractice suits. I don't seem to be able to develop these faculties so what to do? Adjust or quit?

I couldn't adjust to seeing my rancher friend go broke, trying to pay for his wife's unsuccessful six-year cancer fight, or to the child who died of meningitis because his mother saved the cost of a house call three days ago. You all know what I mean, and you respond according to your point of view.

Why public health? Because public health is "socialized" medicine which does not place the health of the public in the market place to be bartered as a commodity.

HAVING made my decision to leave private practice, I proceeded to earn my public health union card, an M.P.H., at the University of California School of Public Health in June, 1960.

I picked California's most unhealthy county to ply my trade: Imperial County is located in the Southeastern corner of California on the Mexican border. Sixty-five years ago it was an arid desert wasteland. Today it is California's newest county, one of the most productive agricultural counties in the world, irrigated by an extensive system coming from the Colorado River. Its economy is purely agricultural, with a total annual production of one hundred and fifty million dollars in crops and livestock. Much of the land is controlled by absentee corporations.

Minority groups comprise one third of the resident population, and these include Mexicans, Negroes, and Asiatics who have migrated here to pick the crops. These groups contribute heavily to the low housing, income, and educational levels of Imperial County. The county has problems of poverty, dependence, illness, and crime.

In 1959 over 80 per cent of all seasonal labor in the county was foreign, supplied by contract with the Mexican government under the so-called Bracero Program.* About 5000 domestic seasonal workers also work in the fields and earn an average of 85¢ an hour. The depressed wage scale is a direct effect of the Bracero Program. In terms of the Mexican economy, the bracero considers himself extremely well paid at 85¢ an hour, but the domestic agricultural worker finds it impossible to support his family on this wage. In times of misfortune, therefore, many domestic agricultural workers are forced to rely on the welfare department for financial aid or to migrate elsewhere in search of employment.

The health and medical services of the domestic agricultural worker are a continuous problem for the local health department. The incidence of tuberculosis and venereal disease is among the highest in California. Six per cent of the adult population are alcoholics. The county has long had the highest infant mortality rate in any of California's 58 counties.

Faced with such problems, my first recommendation to the Board of Supervisors was to remove the irrational separation between preventive and therapeutic services rendered by the county to the indigent. Traditional public health practice, limited as it was to an emphasis on preventive medicine, was misplaced in this environment, since the most pressing need was for adequate medical care and services. Most of the indigent in Imperial Valley waited until they were sick to seek medical care. I felt that the efficient and humane treatment of illness would serve as a firm foundation for the acceptance of preventive services by these families.

Despite pressing needs, however, the local Medical Society, as a part of its fight against socialized medicine, had for more than three years boycotted a state program which provided out-patient services for indigents under the welfare program.† The level of medical care at the county hospital run by two full-time physicians was shocking to anyone accustomed to high standards of medical and hospital practice; with rare exceptions, local physicians took little interest in treating indigents at the hospital.

After four months' study and analysis, I had a frank discussion with the local medical society about the many problems confronting indigents and they agreed to work in cooperation with our Health Department in an attempt to set up a comprehensive program for the care of indigents. This proposed program consisted basically of closing the county hospital and pooling all available public funds to insure indigent patients for full care in private offices and hospitals. The program was to be policed by the local medical society sitting in a committee which

*The word *bracero* is derived from *brazo,* meaning "arm" in Spanish, and refers, of course, to the strong right arm of the farm laborer.

†As in other states the basic welfare program is administered locally and financed by federal, state, and local money. The local program for medical care is derived entirely from state and federal matching funds, with no contributions made locally.

Outspoken Doctor Quits in a Storm

By David Perlman
Chronicle Science Writer

A former Bay Area physician has resigned as health officer of Imperial county in a storm of controversy triggered by his outspoken views on organized medicine, it was learned yesterday.

In a rare personal attack, his views have been assailed as "hostile" and "disruptive" by the president-elect of the California Medical Association.

He has also been accused by Imperial Valley lettuce growers of siding with labor during this year's strife-ridden lettuce strike there.

The target is Dr. Paul F. O'Rourke, 36, who left his flourishing private practice at Novato, in Marin county, a year ago to take the job of public health director in a county where migrant workers and Mexican braceros create an unusual health problem.

FLAG SALUTE

His resignation in El Centro was triggered by a public outcry that arose when his wife, an active Quaker, refused to salute the flag at a recent Democratic party meeting.

The incident climaxed a long series of events marked most strongly by opposition to Dr. O'Rourke from leaders of organized medicine.

In his letter of resignation the doctor said:

"Intimations have been whispered that my wife and I are Communists. This is a ludicrous and ugly lie."

Dr. O'Rourke asked the Imperial County Board of Supervisors last Monday night to consider his resignation at its next meeting. Instead, the board voted unanimously, to accept the resignation right away. It will be effective May 15.

"This was not a resignation, it was practically a discharge," Mayor Wallace Tow of El Centro told The Chronicle yesterday.

'PRESSURE' TOLD

"The local medical society was in the background on this, and there was definitely pressure from the growers. I hate to see a man's professional reputatoin put on the line because of his wife's religious beliefs."

Reprinted from the San Francisco Chronicle April 28, 1961.

would include the Public Health Officer and the Welfare Director. The basis for this approach was my conviction that segregated medical care is inferior medical care.

MEANWHILE, in January, 1961, organizers for the A.F.L.-C.I.O. sent strikers into the Imperial Valley for the first time in thirty years, and attempted to organize domestic farm workers. Tensions mounted as large farm operations were struck. Five hundred citizens (most of them farmers) were deputized by the sheriff to keep law and order. Men with shotguns could be seen walking the main streets of El Centro. The strategy of the organizers was to attempt to establish the presence of a legitimate strike. This in turn would require the State Department of Employment to decertify any struck farm for the use of braceros, since the law prohibits the use of braceros to break a legitimate strike. Growers felt anxious and threatened, fearful of losing control of the harvest of winter lettuce, through loss of braceros upon whom they obviously depended very heavily.

Union strategy worked on several large farm operations and the situation became critical. A "Citizen's Committee to Harvest the Crop" was formed and began to urge private citizens, business people, and even county employees to join ranks and pick crops on the struck fields. Loyalty

to the position of the grower became a civic cause in order to "protect the economy of the entire community."

The Health Department, under my direction, was determined to remain neutral during this battle. The growers demanded that the Health Department apply stringent sanctions against strikers for urinating along the ditch banks while they were picketing. This demand was made even though the growers had previously opposed, with success, an effective local ordinance calling for mobile sanitary facilities for field workers during the harvest operation. Our department refused to take any action against pickets.

About the same time, a request was made that the labor temple kitchen, which was feeding strikers, be closed because of unsanitary conditions, although the facility was located outside of the jurisdiction of the Health Department. Again I stood firm and informed the growers that the Health Department would remain neutral in the affair and would not use its enforcement powers for or against either side. The die was cast. Neutralism in the eyes of the growers and the business community was disloyalty. Dr. O'Rourke had shown his hand as a labor sympathizer, sent furtively to the valley to harass growers and to promote the feared unionization of agricultural workers. He had to go. It was now only a matter of time.

In February, violence erupted in one of the labor camps and about 40 strikers were jailed, charged with false imprisonment of braceros within a labor camp, conspiracy to commit violence, and riot. They were held on bail averaging $7000 each and consequently became residents of the county jail. During a preliminary hearing, an attorney for the strikers complained that jail conditions were dangerous to the health of the inmates. Once again a critical challenge was presented to the Health Officer. The sheriff, in order to refute the strikers' accusations, demanded a sanitary inspection of the jail, apparently expecting a whitewash.

I carried out the inspection, guided by legal statutes which defined minimum sanitary conditions in county jails, and submitted a factual report to the Board of Supervisors and the sheriff. I called attention to hazardous plumbing defects, very inadequate diet, serious crowding, and dirty jail cells. I added, however, that these conditions were probably no worse than in many other California jails. The report caught front-page headlines and was represented as "an attack upon the sheriff." The disloyalty of the Health Officer to his community was finally laid bare for all to see.

A leading lettuce grower now led an open move to remove the Health Officer from his job without further delay. He accused me of representing an "alien philosophy" and of using my office to favor organized labor. The supervisors, under severe pressure from the growers, read the jail report and visited the facility. The conditions that I had described were still present! The supervisors, for the moment, withstood pressure to remove me.

Very rapidly, a rumor began to spread in the community: "Dr. O'Rourke and his wife are communists!" Evidence to support this accusation was whispered by patriotic citizens who had recently learned how to identify communists at a so-called "Freedom Forum." These public meetings, which sometimes lasted two or three days, were held by an organization called the "Christian Anti-Communist Crusade." Respectable people in the valley, including many of its professionals, teachers and students, attended the lectures and were urged to look for communists, not only among the working classes but in the churches, professions, and especially in the government, where the effect of Red infiltration was particularly dangerous. A communist, they learned, could be identified by piecing together certain patterns of behavior. Those actively engaged in agitating for such causes as racial equality, civil rights, federal aid to anything were suspect; also, those who favored fluoridation of the water supply, the United Nations, cessation of nuclear testing, foreign aid to depressed countries, community mental health programs, fair employment practices. Any one association did not signify guilt, but when enough of these allegiances were combined, the time for alertness had arrived.

Unfortunately, my wife and I fitted the description all too well. Although I had seldom ventured my political opinions in public, my wife was an avowed pacifist and Quaker. She had adopted an interracial family, attended liberal Democratic club meetings, went on occasion to a Negro church with her full family in tow, and at one time had even attempted to find a home in her neighborhood for a friend who was a Negro psychiatrist. She was on record as favoring reforms within the Bracero Program and had been guilty of collecting and distributing clothes to the poverty-stricken children of Mexicali, Mexico, on the pretense of "promoting peace and international understanding." Paid investigators had determined that we were members of the American Association for the United Nations and the American Civil Liberties Union.

The final, absolute confirmation of our disloyalty came accidentally, ten days after the furor over the jail report, when Mrs. O'Rourke was noted abstaining from the Pledge of Allegiance at a meeting of the Democratic Club. Pressed in public for an explanation, she stated that her abstention was a matter of private and religious conviction. Local newspapers headlined this event and it was obvious now that Dr. O'Rourke was ready for the axe. The supervisors were flooded with irate phone calls demanding that I be fired. A meeting was called promptly and was attended by an outraged crowd of growers, citizens, and physicians who sat poised, listening carefully as I read a statement, a part of which I quote here:

> "Recently, my wife publicly declined to participate in the Pledge of Allegiance to the Flag on the grounds of conflict with her convictions.
>
> "I disagree with her position, but believe implicitly in her integrity and sincerity. I defend publicly her

right to take this position according to the dictates of her conscience. Her conviction is that her first allegiance is to God and that in the eyes of God all men are equal. She considers warfare to be immoral, and believes that nationalism eventually has to give way to international cooperation in the interest of peace. She is a good and loyal wife, a good and loyal mother, and a good and loyal citizen. I am proud of her.

"When I salute the flag I do not do so as a mechanical proof of my patriotism but rather as a thoughtful dedication to those guarantees of freedom symbolized by our flag. I teach my children that the most important of these guarantees is freedom of thought and religion and that these freedoms are extended to all, including the small minority whose beliefs preclude the salute. Above all, I want them to understand that to coerce or to compel this pledge in any way destroys its meaning for all of us.

"I know that my wife's actions are widely misunderstood and have frightened many people. I am aware that, in spite of the fact that I do not share many of her beliefs, this reaction may threaten to affect competent operation of the Health Department. I wish to submit my resignation for your careful consideration. I ask you to place paramount importance on the welfare of all the people of this county, which, I believe, transcends personal considerations. Whether you accept this resignation or decline it, I will cooperate fully with your decision in the interest of the important work which I share with so many respected colleagues.

"Intimations have been whispered that my wife and I are communists. This is a ludicrous and ugly lie."

I had initiated this meeting of the Board of Supervisors and intended that the offer to resign would either be accepted or that I would be given a vote of confidence. I realized that unless I took prompt action, some equally false issue would be raised to justify my dismissal.

Following my statement, I left the room. During the ensuing 45-minute discussion I was accused of dishonesty, incompetence, and advocacy of socialized medicine. An article which I had written to my colleagues when I left private practice was read verbatim to substantiate these accusations. The article was accompanied by two letters (from a prominent medical politician who had been) a former medical colleague during my term of private practice. (He) described me as "holding an attitude toward the medical profession that is not only hostile but indicates that he is basically interested in massive social changes that from my point of view would be most disruptive." He had warned the society in a second letter that "full cognizance should be taken of any statements or activities that he has been engaged in, serving as Health Officer in Imperial County." The physicians of the community translated these letters rapidly: Dr. O'Rourke is indeed a communist. They joined the representatives of the growers and urged the Board to accept my resignation. The Board complied.

The next day, however, a storm of protest broke throughout the San Francisco Bay area in response to front-page coverage by the *San Francisco Examiner* and *Chronicle*. The resignation was also headlined in the local press. The State Health Department, during the week that followed, warned that the County Health Department might lose significant financial support in the form of state subsidy. The Director of the State Health Department supported me and gave his opinion that I had done an impressive and imaginative job in Imperial County. At two special meetings, the Board of Supervisors refused to reconsider the resignation, but one week later, under mounting pressure from the community, they rescinded the resignation and reinstated me with a unanimous vote of confidence.

During the week of uproar which had followed my resignation, an agonizing reappraisal of the O'Rourke family had occurred. An avalanche of mail from friends, former patients, and colleagues expressed outrage at the action and attested to our good citizenship and loyalty. During the last hours before reinstatement, several respected local citizens came before the Board and stated that they had been completely wrong and had accused me and my wife unjustly. It was a heart-warming event for both of us.

In the weeks that followed, the strikers came to trial and all but two were freed of charges. As summer neared, the A.F.L.-C.I.O. admitted defeat in their attempts to organize agricultural labor and withdrew their organizers to work in northern counties of the state.

When the Health Department attempted to return to business as usual, however, our efforts proved fruitless. I was visited with regularity by individual members of the Board of Supervisors who stated frankly that I had become "too controversial" to be effective. They knew and admitted that they could not fire me, and, after a sixth request, I submitted my resignation on the first anniversary of my arrival in Imperial County.

I left the valley with a sense of tragedy. At the time of this writing, no Health Officer has been found. A rash of resignations followed mine and the newly built health center stands, for the moment, an empty shell.

At present I am located in Santa Rosa, California, serving as Director of Preventive Medicine in a pre-paid comprehensive health plan sponsored by ten local labor unions. I can only wish that the enthusiasm for maintaining health and providing quality medical care, shown by these union leaders, were shared by the supervisors of Imperial County, whose people have such desperate needs.

The lessons of such an uncomfortable and unforgettable experience are hard for the victims themselves to dig out. What had started as a problem in medical politics ended in an attack against freedoms so fundamental and indispensable that no democratic community bereft of these can long survive.

FALLS

Wax effigy of Pope John XXIII

A WAX MUSEUM FOR NIAGARA FALLS

In 1959 I developed an interest in tourism in Niagara Falls and became involved in the Louis Tussaud Wax Museum. The original idea for this project evolved because we believed that tourists, particularly Americans, are interested in seeing something English when they are visiting Canada rather than looking at the American flags that so many Canadians place in front of their shops. In other words, we endeavoured to get something different rather than the usual honky-tonk attraction that one so frequently sees. We were interested in having only a first-rate attraction.

The Niagara Museum is the only Tussaud Wax Museum on this continent, since our group obtained exclusive rights for all of North America. Tussaud artistry began two centuries ago during the French Revolution in musées operated by Marie Grosholtz and her uncle, a renowned wax modeller in Paris. During the reign of terror, Marie was imprisoned and forced to make death masks of the royalists who were guillotined by the Revolutionary Government. After her uncle's death she married François Tussaud and moved, wax-works and all, to London.

We are associated with the present Louis Tussauds of London and Blackpool and obtain all our figures from that still-thriving enterprise. All wax figures are duplicates, but they are duplicates of the original clay sculptures which are never displayed.

In initiating this Museum we were, of course, concerned with the financial risks since the cost of the project was high. But the box-office draw of wax celebrities being what it is, the project has had an astonishing financial success and was recently written up in Canada's financial paper, *The Financial Post*. Soon we will have 125 figures in the Museum and our hopes are to improve it all the time. We have had offers from major U.S. cities and other areas to open another museum but we are naturally weighing these possibilities at considerable length.

Why has this Museum been such a financial success? We believe that there are several factors involved. It is, first of all, what people seem to want. (And I might say that tourist psychology has, for me, been one of the most interesting aspects to evaluate.) As far as the tourists are concerned we have an excellent location, the cross-roads of Niagara Falls. About 500,000 people have now passed through the doors so we are well on the way to a million in the next six months. On some days, as many as 4,000 people walk through the Museum. Another factor is our year-round operation, in contrast to many other tourist attractions. Also, the museum setting in the public rooms of the Sheraton-Foxhead Hotel, an Old-English style building, helps to create an interesting atmosphere for the tourists and an excellent backdrop for our assorted wax personalities. Of course, a great boon is the Tussaud name which is internationally known and of excellent reputation.

Since the opening two years ago we have had royal recognition from the press, radio, and television. Our decision to bring Bloody Mary, Queen Victoria and Beethoven across the Atlantic via Pan-Am Jet as first class

FALLOUT and

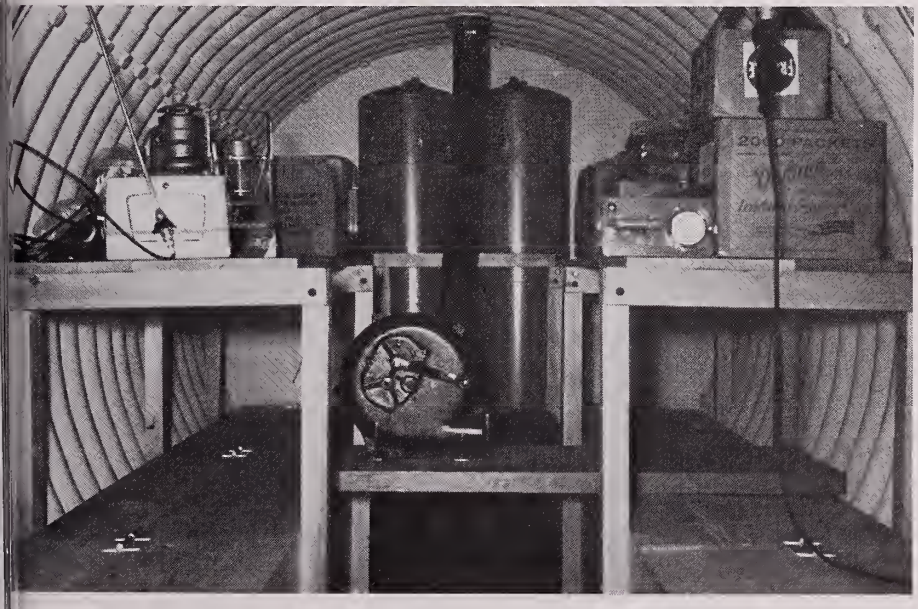
passengers on June 7, 1959 aroused a good deal of attention. Police escorts have been arranged for some of the major figures on their way to the Museum from the airport and Khrushchev was brought across the border in an open car. Yuri Gagarin is now on his way across the ocean on Her Majesty's Ship, *Beverdams*. The airlines also took advantage of a publicity stunt to show models sitting in the airline seats on their flight across the Atlantic. With a write-up in *Life* magazine and appearances on "What's My Line" and the Jack Paar and Garry Moore shows, we have had a million dollars' worth of free advertising.

Of course we have a few minor problems. Some tourists like to touch the figures, and some unfortunately have the nervous habit of breaking off the fingers. Recently a tourist stole John Dillinger's pistol, so you see how human nature runs in odd circles. But in general it is a good compact business to operate, and 99 percent of the customers seem thoroughly to enjoy the show.

KENNETH F. WALKER '50

AUTHOR'S NOTE:

Dr. Walker is a gynecologist and author practicing in Niagara Falls, Canada. His interest in tourism extends beyond the exclusive Louis Tussaud Wax Museum described in this article and he is currently involved in the building of a new Seagram Towers, 300 feet high, overlooking the Horseshoe Falls and featuring observation floors and a penthouse restaurant. Professionally, he has just published under the pseudonym, "W. Gifford-Jones," a book entitled Hysterectomy? A Book For the Patient, *published by the University of Toronto Press in Canada, and Thos. Nelson and Sons in the U. S.*



Interior view of Dr. Davies' Wellesley Hills shelter

A SHELTER FROM BLAST, HEAT AND FALLOUT

If you have been thinking about how to give your family a chance of survival in a nuclear war, I hope the following account of my shelter will help you.

The Hiroshima bomb yield was about 20 kilotons. The largest nuclear weapon yield today is about 20 megatons. A 20-megaton detonation creates a blast wave which can collapse frame dwellings at 15 miles, and a heat pulse which will start widespread fires within a 25-mile radius. No practical means of protection exists at present within a 2-mile radius, but beyond this distance effective protection against blast and heat is possible. Dr. Solomon Garb reported studies on this problem by the Medical Education for National Defense (MEND) Committee of Albany Medical College in the 1960 *New York State Journal of Medicine*, and this work should constitute basic reading for anyone contemplating the construction of any type of shelter.* It is important to realize that the present Civil Defense program is con-

*A free copy can be obtained by writing to James Dougherty, M.D., MEND Coordinator, The Albany Medical College of Union University, 47 New Scotland Avenue, Albany 8, New York.

FALL IN

cerned only with protection from fallout and offers no plan for realistic protection from blast and heat. Even the OCDM underground reinforced concrete shelter will probably collapse under overpressures above 5 lbs. per square inch (psi).

Early this summer, after months of planning, I installed a 6-foot diameter, 16-foot length of corrugated, twelve-gauge steel pipe in the back yard of my home, buried under five feet of earth. This watertight structure is designed to resist blast overpressures of 100 psi, a practical maximum of protection, since this is the overpressure at the edge of the fire ball of a 20-megaton detonation. The earth cover above the shelter affords excellent protection from direct and fallout radiation. The entrance tube of 42-inch diameter corrugated steel pipe slants down from an opening in the basement wall, turning at a right angle before reaching the shelter to reduce the possibility of gamma radiation scatter. Such a prefabricated shelter costs about $1500. This one was made by the New England Metal Culvert Co. Additional excavation costs might vary from $100 to $1000, depending upon local problems, i.e., ledge, shoring requirements, etc.

The ventilation problems of such a shelter demand careful consideration. Tests have shown that an increase in the carbon dioxide concentration to 3% coupled with an oxygen decrease to 17% is the practical limit for prolonged safe occupancy. Each occupant requires a minimum of 5 cfm of fresh uncontaminated air to keep the carbon dioxide content in the shelter below 1%. To control humidity and odor it is wiser to plan for 10 to 20 cfm per person. Due to mixing of fresh with stale air, the capacity of the ventilation system should be more than just adequate for these requirements. Outside air is drawn through an underground steel pipe duct system which has a filter capable of removing the smallest particulate radioactive material. The filter should have a capacity larger than the blower and the duct system should be 4-inch diameter pipe to reduce the resistance of air flow. My filters were made by Flanders Filters, Inc., Riverhead, New Jersey. A suitable filter costs about $75. A large "S" type truck muffler is placed ahead of the filter to protect it from a blast wave coming down the duct from above ground. The air is drawn through the duct-filter system into the shelter by a hand-cranked blower. My 100 CFM blower was made by the Champion Blower & Forge Co., Lancaster, Pa., and cost $80. The capacity of my ventilation system for a shelter volume of 450 cubic feet for 4 to 6 occupants is 100 cubic feet per minute. This permits intermittent operation of the blower — about 5 minutes every half hour. Stale air is exhausted by slight overpressure through a similar duct-filter system. Either system can be used for air in-take, so that there is a spare filter.

A Horseman's Paradise: Lowell F. Bushnell '33 leads at left

It is a simple matter to build some type of interior wooden staging. Two 40-gallon galvanized water storage tanks are located at the far end of the shelter. Our food supply consists of canned hash and fish, peanut butter and tinned crackers. A chemical toilet handles solid excreta; urine will be poured down a drain plug at the bottom of the shelter. A transistor radio with auto antenna, shielded cable and booster gives fair radio reception underground. Continuous lighting is supplied by a 6-volt 150-milliamp bulb attached to a heavy duty 6-volt auto storage battery. A good radiological survey meter is indispensable — mine is a CDV-720 model, made by the Victoreen Instrument Co., 5806 Hough Avenue, Cleveland, Ohio — price $90.

It is my opinion that realistic protection from nuclear attack can be obtained at moderate cost. I have written this article in the hope that many of you will become aware of some of the practical steps that can be taken to solve this pressing problem.

Frederick M. Davies '50

Frederick M. Davies '50 practices general surgery at the Newton-Wellesley Hospital, where he is part-time assistant to Ernest M. Daland '18.

THE RANCHEROS VISTADORES RIDE

Somewhat west of Dedham the Rancheros Vistadores Ride has taken place annually for the last 32 years during the first week in May. Leaving Santa Barbara Mission on Sunday morning, the official course traverses the San Marcos Mountain Pass to Solvang, California. Covering a distance of approximately 80 miles, the ride takes a full week, disbanding on the following Saturday morning.

Now a nationally recognized institution, the Rancheros riders at last census represented 37 states from Hawaii to New Hampshire and three foreign countries: Canada, Mexico and France. A true Ranchero classes the Ride as the third of the great movements of history — the Age of Pericles; the Rise and Fall of Rome and, finally, the Growth of the Rancheros Vistadores! The Ride originated in 1928 when ten ranch owners joined for a ride from Santa Barbara to the Santa Ynez Valley in California. So successful and so "soul-satisfying was the comaraderie" which developed during the course of this first ride that the group agreed to meet the next year and thus a tradition began. In succeeding years invitations were issued for others to participate in the ride. The present organization dedicates itself to the "Californios of old, to the fun they had, the land they roamed over, and to the impulse that causes men today, even as then, to want to get out with friends, fork a horse, ride like Hell, and feel the good wind blow past."

The history of the Rancheros, however, dates much farther back than 1928, to the mission days in early 19th-century California. Although they were primarily engaged in saving souls the missions also pioneered in the raising of cattle and were responsible for the beginning of that industry in California. When the rush for land was on, the mission padres lent the colonists and their descendents the cattle to begin their ranches. The ranches grew; servants, field hands and stock hands were hired, and gradually life became more gracious. At round-up time, a great deal of visiting took place among the ranchers as groups rode from ranch to ranch to brand new cattle and help neighbors brand theirs. On the return trip, there was much feasting and celebration en route and the tradition of the rodeo developed. The present Rancheros Vistadores strive to be the "preservers and re-creators of this gay and glowing tradition." But they continue to pay tribute to the missions who gave them their beginnings, always selecting the Mission of Santa Barbara as the starting point for the ride.

To qualify as a Ranchero one need only the ability to enjoy and participate in the ride. There are no economic or social considerations in selecting the members of this very exclusive group. The arrangements are that one must be an invited guest for three consecutive years and then be invited to belong to the waiting list for membership; after which time you may wait as long as 5 to 8 years until you are elected to membership. Robert O. Pearman '35 is also a member. I have hopes that we can encourage a few others of the Harvard Medical Group to become good horsemen. Ride on Rancheros!

Lowell F. Bushnell '33

Rancho Vistadores rider Lowell Bushnell '33 has a private practice in Obstetrics-Gynaecology in Pasadena, California. As secretary of the Harvard Medical Alumni Group of Southern California, he keeps this side of the country well informed about the other side.

Crimson
Harvey J. Hacker
Harvard '63

EMOTIONAL PROBLEMS OF THE STUDENT. Graham B. Blaine, Jr. and Charles C. McArthur. New York, Appleton-Century-Crofts, 1961, 248 pages, $4.95.

Emotional Problems of the Student, by Graham Blaine and Charles McArthur, consists of fourteen chapters written by members of the staff of the Harvard University Health Service, prefaced with an introduction by Erik H. Erikson. In general, each staff member has contributed a single chapter, but the authors are represented more than once. The book describes the types of emotional problems presented by students and the manner in which they are handled by the Harvard Health Service. In addition it devotes some space to describing functions of the college psychiatrist which are not directly related to psychotherapy and to outlining the roles of the different specialists in the over-all staffing of the service.

It joins a small but growing number of volumes exclusively concerned with the emotional problems of the college population. The book in a sense is a modern version of the original Fry and Rostow volume, *Mental Health in College.* The passage of twenty years has increased the range and number of staff members represented in the contemporary large, well-staffed psychiatric service in a major university, and *Emotional Problems of the Student* reflects this extremely well. It is in contrast, however, to the recently published volume from the Yale Division of Student Mental Hygiene, which covers more circumscribed aspects of the clinic function.

The emphasis of the book is descriptive. The authors state that it in part attempts to answer the question, "Why does a college need a psychiatrist?" The book is directed not only to psychiatrists, psychologists and social workers working directly in the health field, but also to faculty members, deans, student counsellors, guidance and personnel workers. To this end it is written clearly, colorfully and with a happy absence of technical jargon, which so frequently acts as a barrier in communication. There is good coverage of the main subjects of interest to the majority of college faculty and the approach, in addition to being professionally sound, has a foundation in common sense that should do much to dispel any lingering feelings among educators that psychiatrists regard themselves as possessors of a mystical, omnipotent knowledge. For professionals in the college psychiatric field it describes most of the types of problems encountered and describes the Harvard experience with the students affected.

The list of chapters gives some idea

BOOK REVIEWS

of the scope of the book: The Role of the College Psychiatrist; Faculty Counseling and Referral; The Role of the Psychologist in a College Health Service; Distinguishing Patterns of Student Neuroses; Problems Connected with Studying; Basic Character Disorders and Homosexuality; Acute Psychosis, Depression, and Elation; Suicide; Student Apathy; Emotional Disturbances Among College Women; Special Problems of Graduate Students in the School of Arts and Sciences; Special Problems Encountered at the Graduate School of Business Administration; Psychiatric Problems of Medical Students; and Therapy. Each is a separate and complete article, written from an individual viewpoint but linked by the common source of data and the effect of working in a professional group with a more or less common approach.

Inevitably, there is some unevenness in the chapters, both in type of treatment and in material covered. Some subjects are treated from the statistical standpoint, some chapters are purely descriptive, and one or two attempt a theoretical approach. Although this makes for a certain variety, it also leaves the reader feeling that there are a few gaps in the over-all description of the service. The subject matter, however, is always of interest and much pertinent and useful information is included. Relatively little attempt has been made in this volume to discuss and compare the Harvard experience with reports from other clinics, and it is to be hoped that the future will bring an additional volume devoted to further elucidations of the problems described.

ROBERT L. ARNSTEIN, '51

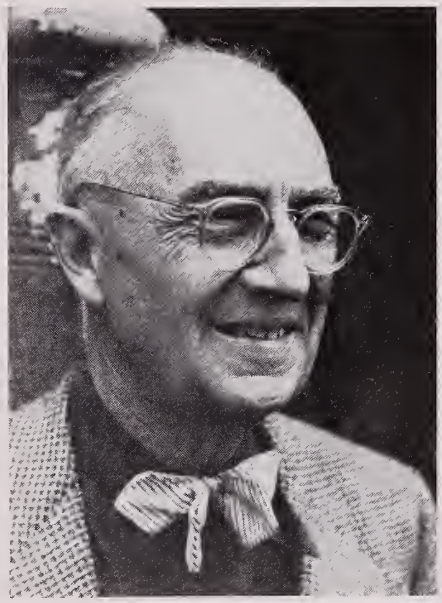
Dr. Arnstein is Psychiatrist-in-Chief of the Division of Student Mental Hygiene in the Department of University Health, Yale University.

THE FARMERS' DAUGHTERS, THE COLLECTED STORIES OF WILLIAM CARLOS WILLIAMS. $4.50, New Directions, N. Y., N. Y., 1961 (also in paperback #106, $1.95).

In the *Farmers' Daughters and Other Stories,* a collection of fifty-two short stories and sketches, William Carlos Williams reveals much of himself as a physician and as a poet. He fulfills many times over the desire of Helen, one of the heroines of the title story, who says: "Oh, I wish some day I could write a story, a true story about people . . . They're just like us."

Some of the stories are based on Dr. Williams's memories of his childhood in Rutherford, New Jersey. Others tell of adventures of friends such as the officer who sailed the North Pacific on a revenue cutter and feasted with Russian sailors between hunts for seal poachers. But most of the tales are derived from his experiences in medicine, first as an intern in obstetrics and children's diseases at the French Hospital in New York, then as a physician in the Rutherford-Passaic region of New Jersey. He writes of home deliveries and kitchen-table appendectomies, of erysipelas and congenital heart disease, of manic depressives and homosexuals, and in so doing, he describes the practice of medicine during the past forty years among a population composed predominantly of German, Polish, and Italian immigrants.

Dr. Williams also speaks of what it is to be a doctor. In *Old Doc Rivers,* he shows the conflict that arises in a man of many interests and talents between his dedication to his patients and to his own self-expression. In the case of this surgeon, who was still active in Rutherford when Williams was just entering practice, the result



John D. Schiff

Dr. Williams

was tragic: he became an addict who needed cocaine to steady his hands and fortify his will in order to treat the sick. Fortunately for literature, Dr. Williams has succeeded in satisfying the demands on his time made by medicine and by writing. In these stories, he reveals, with complete honesty, his own reactions to his patients: the exasperation at being called from the dinner table and from bed; the anger, first towards the parents, then towards himself, and finally towards the little girl who fights off his attempts to examine her throat; but most of all, the love and trust built up between doctor and patients as exemplified by Angelina, who after the successful delivery of her eighth child, rewards him "with the peculiar turn of the head and smile by which [he] knew her."

As a doctor, he participated in isolated, but usually critical, episodes in the lives of his patients, moments

which enabled him to learn much about their personalities from their reactions to illness. As a poet, he listened to everyone he met and absorbed what he heard in order to create the language of these stories. Writing in a conversational style, without the use of dialect and with never a superfluous word, he has here, as in his poetry, caught the rhythms and sounds of the speech of modern America.

RONALD GOLD, '62

Dr. Gold writes poetry in his spare time, "which is very limited as a fourth year student." His comment: "I'll have to wait until I get onto some of my electives."

ONE FOR A MAN, TWO FOR A HORSE, a Pictorial History, Grave and Comic of Patent Medicines, by Gerald Carson, 128 pp., New York: Doubleday & Co. $6.50.

The title page shows a bearded old fellow and a happy horse, tucked in a quilt-covered bed, pondering Pratt's Healing Ointment for Man and Beast. From this advertisement comes the title for this delightful "souvenir in words and pictures" of the quackery of patent medicines in the United States, "recalling (in words and pictures) the fads, follies and foibles of self-doctoring in grandpa's day."

Quackery is the constant companion of medicine — it merely changes in relation to the law, social custom and the communications media. Printing encouraged the testimonial technique and the patent laws of the 1700's ushered in patent medicines. The small-scale patent medicine business swelled into wholesale concerns by introducing national advertising in magazines and newspapers. "Secret" trade names and panacea "ads" saturated the family and religious magazines. The companies made millions and their advertising techniques have led to the same "pill-box Barnums." A representative case is that of the local lady from Lynn — Lydia Pinkham, who catered to many Victorian ladies. Her "vegetable" compound helped ward off "leucorrhoea and ulceration of the womb" with a socially acceptable concoction *preserved* with 18% alcohol.

At the time of the Civil War scientific medicine was making gains, but the medical man could do little in many cases. His theory, diagnosis and treatments were often vague and generalized. As the expression goes — "When authorities disagree — fools may choose" — and they did. The need for certainty was satisfied with specifics as Aunt Betsy's Green Ointment, Black Draught, Carter's Little Liver Pills, Kickapoo Indian Sagwa, Pink Pills for Pale People, Swamp root, Pinelyptus Pastilles, Peruna, Worme's Gesundheit Bitters, and the like. This book contains about 250 illustrations from old pictures, posters, photographs, almanacs and advertisements. Open the pages to bold black print, long skirted women holding their backs with pain, bearded generals endorsing a mixture, bare-breasted Indian maidens, Gothic print and nephrotic-looking children in pastel colors. You may learn that Sarah Bernhardt approved of both Duffy's Pure Malt Whiskey and Paine's Celery Compound. It also revealed that Nuxated Iron helped Jack Dempsey whip Jess Willard.

This book reeks of that old drugstore smell and evokes the memory of row after row of handsomely labeled bottles behind oak, glass paneled cases, and those mysterious, red and blue liquid-filled hanging jars.

The exorbitant claims of the "patents" resulted in the Food and Drug Act of 1906, but the book provokes thought of drug advertising today. "Cultural lag" is still with us. The ballyhoo on television still advocates the cure-all and specific. The younger generation must think the esophagus is a spiral glass tube designed so that pills can disintegrate by the time they reach the stomach which is equipped with a gate-like little mechanical valve. The "junk-mail" sent to physicians still advises magic combinations, and its claims are overstated. One year, in the 1950's, a potion called Hadacol (name derived from the first syllable of *Ha*ppy Day *Da*y *Co*mpany) made $5,000,000 for its promoters and last year a book advocating vinegar and honey as a cure for practically every disease known to man was on the bestseller list.

The book is entertaining. It is perfect for the bedside stand and the waiting room.

GEORGE E. GIFFORD, JR., M.D.

Dr. Gifford is a psychiatrist at the Peter Bent Brigham Hospital. He has just completed an M.A. in the history of science at Harvard and is interested in ornithology and the history of medicine.

Egyptian Regulator Tea said it gave Mabel Gray, "The beautiful but frail courtesan" of London, vibrant bust beauty, and promised the interested public an enlargement of from two to six inches in the appropriate places. The tea was also sold as a freckle-remover. It was a physic.

"AND HER GOLDEN HAIR WAS HANGING DOWN HER BACK"

In the spacious days of William B. McKinley, the dollar watch, and the three-dollar shoe, the seven Sutherland sisters came upon the town with a preparation which they sold by demonstrating their own luxuriant locks. Sara, Victoria, Mary, Dora, Isabella, Grace, Naomi not only had the longest, thickest hair ever seen in Niagara County, New York, where they hailed from — they had THE LONGEST HAIR IN THE WORLD. Their hair and their tonic transformed them into fairy princesses swathed in furs, dripping with diamonds. *(Illustrations are from the book, One for a Man, Two for a Horse.)*

The Sutherland tresses were brown, not golden, as in the old song, but they were hanging down the girls' backs, all right. When, during their musical act in the Barnum and Bailey show, they did a reverse and all presented their derrieres to the spectators, the combined length of crowning glory was thirty-six feet, ten inches. The sisters were all big, strong farm girls, not ravishing beauties, but handsome enough. They could sing a little and play a little, and they got by all right.

THE WORLD-RENOWNED SEVEN SUTHERLAND SISTERS

George Parkman Denny

1887-1961

EVERYONE in any way connected with Harvard Medical School for the past 50 years knew or at least knew about George Denny. They have lost an irreplaceable friend and advisor.

He entered the Medical School with the Class of 1913, trained at the newly opened Peter Bent Brigham Hospital, had a short period of postgraduate work at Johns Hopkins and, having married in 1914, returned to Boston to engage in the practice of medicine.

He joined the permanent medical staff of his old hospital and, in addition, came under the influence of Dr. Henry Jackson, Senior. In the hospital he was able to further his interests in clinical research, notably on problems of heart disease. Under Dr. Jackson's influence, he developed to a fine art an already great ability to understand and treat patients. To be sure, he was working under a master in the field, but to the former's skill and experience, George added a kindly and, at times, devastating humor that was his own particular attribute.

Although his patients ranged from a cook in Roxbury to the late J. P. Morgan, no distinction was ever made on account of wealth, poverty, influence or any other factor. All were treated with the same kindly and careful, efficient interest that is the hallmark of the truly great physician. It was therefore inevitable that his patients adored him, imposed upon him regularly and never left his care if they could avoid it. In return, he was at their beck and call at all hours of the day and night. He failed to collect much that he would otherwise have had, had he bothered about sending out his bills properly; was the repository of many family skeletons which, had they been allowed to escape, would have sunk many a family ship; and was beloved by all with whom he came in contact.

This gift of friendship was as effective with the young as with the old. During his early years of practice he was in charge of the health of the Harvard crews at Red Top and of the health and scholarship arrangements for the students of the Harvard Medical School. All who dealt with him in those early years remember and speak of him with great affection.

In his later life, he demonstrated an extraordinary capacity for organization and administration. The largest Veterans Administration Hospital in New England is and will remain a testimony to his capacity along these lines. It was organized, started and given permanent character under his managerial guidance. As evidence of the affection in which he was held by the personnel, even after his retirement from the hospital, a memorial service in his honor was organized by the hospital staff, and the non-professional members from cooks and porters to secretaries subscribed to a sum of money which was presented to the Beverly Hospital in his memory. (George had long been a member of the staff of this hospital.)

His talents were put to many other uses. He was an Overseer of Harvard University and served on the Visiting Committee for the Medical School. He was elected president of the Medical Alumni Association; he was instrumental in organizing and was a member of the Deans' Committee, which made possible an active teaching association between the Veterans Administration and the medical schools of the Boston area.

He served as a medical officer in the American forces during both World Wars and in the same capacity with the British in the First World War. He was decorated by the United States Government with the Legion of Merit for his services during the Second World War. He was discharged from the Army with the rank of Colonel after serving as Medical Consultant to the First Service Command. In this latter capacity he visited all medical installations in their area including Iceland.

Such devotion to his country might have been predicted, for his paternal ancestors fought with Washington's troops during the War of the Revolution. His grandfather, whose name he bore, was Captain of A Company of the 45th Regiment of the Massachusetts Volunteer Militia and fought in the Civil War and his father was an officer in the American Navy during the Spanish-American War.

He was a member of a number of clubs in college and medical school; of the country's chief medical organizations, and of many medical dining

and other Boston clubs including the Tavern and Somerset.

George was a reticent man with few intimates. He possessed abiding loyalties, however, and an effective generosity that he kept hidden at all times. It was, for example, typical but not unusual of him to come, as he did in one instance, to the worried wife of a colleague and offer to take care of the financial stringency that was the cause, not only of the wife's distress but of the prolongation of her husband's illness, with the sole proviso that no one, and certainly not the sick man, should be told of his action. The principal beneficiary recovered, but it was not until long afterward, and then only by chance and after George's death, that he learned about the effort that had been so generously made to lighten his load.

George is survived by his wife, 3 children, 12 grandchildren and a widowed sister. He was devoted to his family and they to him. Their loss cannot be adequately measured by those outside the family circle.

Next to his family he loved his work and his profession and — as an essential part of it — people and human companionship. He found the means for the latter at the Tavern Club, where he was greatly beloved.

His life's work, the training he had had, his temperament, his dedication to and primary concern with the patient as distinct from the disease amounted almost to a passion and was rewarded with affection, cooperation and renewed good health to a degree that is given to few physicians.

Surely in this instance, we may obey the Biblical injunction to

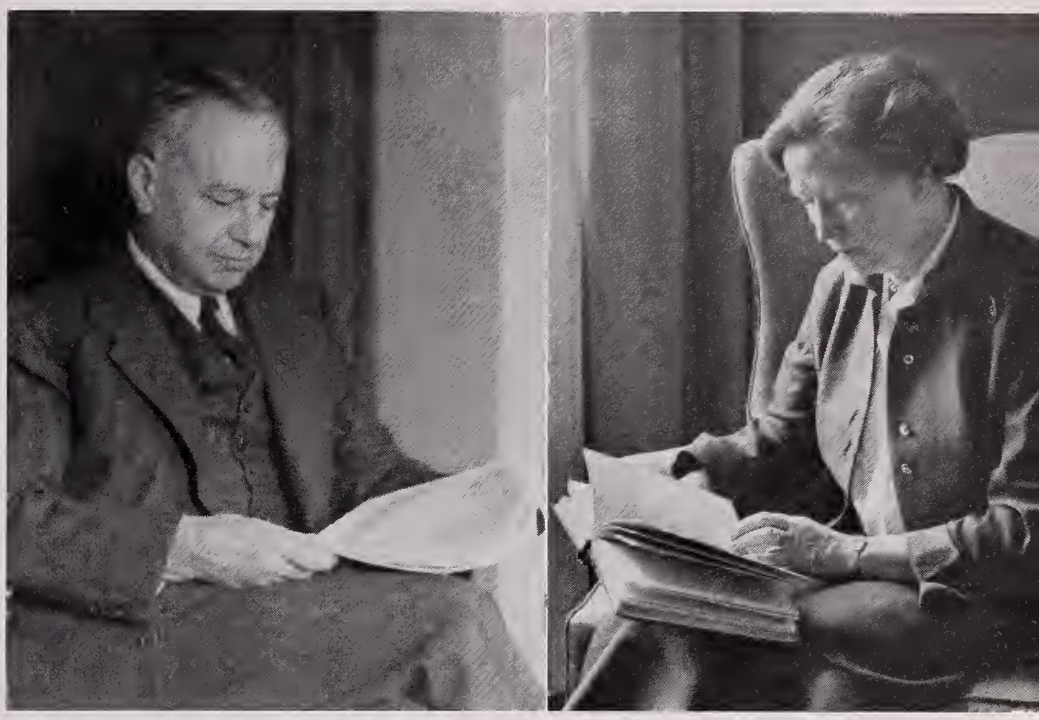
> "Honour the physician for the need thou hast of him: for the most High hath created him. For all healing is from God, and he shall receive gifts of the King. The skill of the physician shall lift up his head, and in the sight of great men he shall be praised . . ."

and be proud to have been privileged to have known him.

A gentle man has left us.

DONALD MUNRO

HONORS



Rustin McIntosh '18 recently won the American Pediatrics Society's John Howland Award for service to pediatrics and has been elected a Trustee of the Children's Aid Society of New York. Our medical school is proud of Dr. McIntosh and his wife Millicent who retires in 1962 after 15 years as President of Barnard College.

* * *

Boston University School of Medicine announced a newly-endowed chair in medicine in honor of CONRAD WESSELHOEFT '11. The first such chair to be located at Boston City Hospital, the Conrad Wesselhoeft Professorship will be in support of two major medical services.

* * *

FRANZ J. INGELFINGER '36, Professor of Medicine at B. U., will be the first incumbent of the Chair and will also direct the fifth and sixth Medical Services at the Boston City. Dr. Ingelfinger came to Boston University in 1940 as instructor in medicine and since has served at the Massachusetts Memorial Hospitals as chief of the gastrointestinal clinic, visiting physician in the medical service, visiting physician at the Haynes Memorial and as a member of the Robert Dawson Evans Memorial.

Part of the bequest for endowment of the new chair was made by the late Miss Anne A. Ramsey, a patient of Dr. Wesselhoeft. Dr. Wesselhoeft, Clinical Professor of Medicine, *Emeritus,* at B. U. specializes in infectious and contagious diseases and is the fourth member of the Wesselhoeft family to serve on the Boston University medical faculty.

* * *

In honor of his long dedication to medicine and humanity, the portrait of WILLIAM PARRY MURPHY was unveiled on September 13 at the Peter Bent Brigham Hospital. In 1925 Dr. Murphy joined Dr. George R. Minot at the Brigham and began the search for a way to control pernicious anemia. In 1934, "for their discoveries concerning liver therapy against anemias," Dr. Murphy and Dr. Minot shared the Nobel Prize in physiology and medicine with Dr. George H. Whipple, Dean of Pathology, *Emeritus,* at the University of Rochester School of Medicine and Dentistry.

Principal speakers at the unveiling ceremonies were Dr. George W. Thorn, Physician-in-Chief, Peter Bent Brigham Hospital, and Dr. Samuel A. Levine '14, Physician, *Emeritus* at the Brigham.

The portrait, painted by Frances Chamberlin Brand, is a gift of Dr. Murphy's many admiring patients and friends.